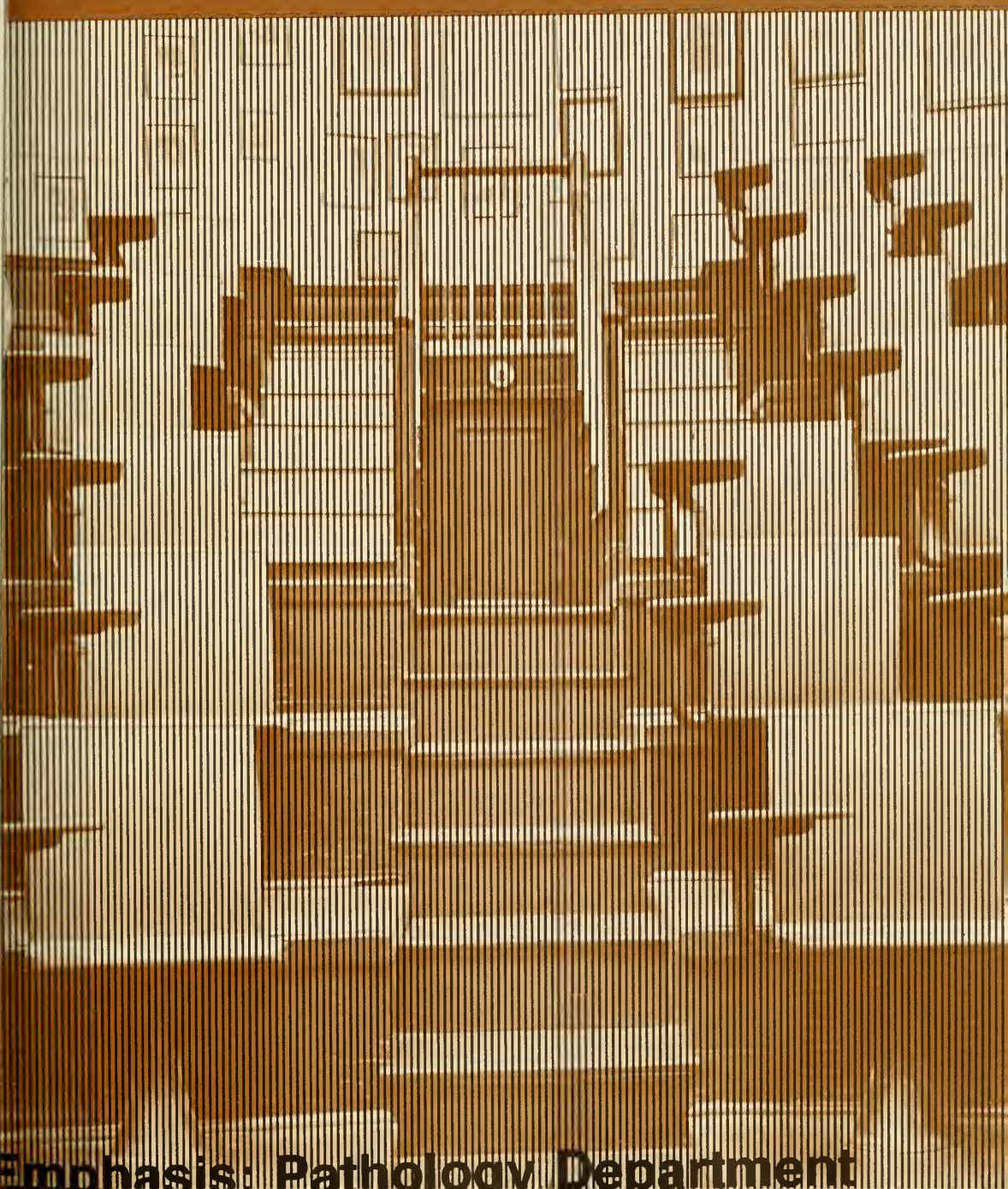
February, 1976

BULLETIN

university of maryland school of medicine



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COVER: "A view from the lectern in Anatomical Hall"

BULLETIN

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February, 1976 **Vol. 61** **No. 1**

Pathology in the Medical School

Peter Rasmussen, M.D.

Acknowledgement: Thanks are due to Dr. Jon Valigorsky for many of the snapshots and Dr. Ben Trump for many suggestions.

The Department of Pathology has a long and distinguished history extending back to the origins of the school. Faculty and graduates of the University of Maryland have contributed significantly to the development of pathology. Some examples are Dr. James Homer Wright, graduate of the late 19th century, known for hematologic studies and development of widely used stains for blood films; Professor Francis Donaldson, an early pathologist at the University of Maryland, who made one of the first studies of the cytopathology of cancer; Dr. Samuel T. Darling who first described Histoplasma capsulatum while in the Canal Zone; and Drs. James Carroll and William T. Councilman, both of whom worked on yellow fever. In recent times Dr. Si Chun Ming was author of the fascicle called Tumors of the Stomach published by the Armed Forces Institute of Pathology.

The present goals of the Department according to Dr. Benjamin F. Trump, Professor and Chairman, are to continue to develop the anatomical and clinical laboratory services at the University and Veterans Administration Hospitals, to develop biomedical knowledge in the areas of basic pathophysiology and to maintain excellent educational programs for medical students, graduate students, house staff and medical technologists.

The organization of the Department parallels these three areas of endeavor at the University Hospital and the Baltimore Veterans' Hospital at Loch Raven Boulevard (LRVAH). Dr. William Tigertt serves as Associate Chairman for hospital services at both hospitals and Dr. Ruth Ellen Bulger serves as Associate Chairman for Graduate Studies and Research. Dr. Trump and the faculty as a whole are responsible for the educational program of the Medical School. Some of the successes and problems in attaining these goals are reviewed in this article.

In the mid and late 1950's the Pathology Department participated in the general renaissance of the Medical School. Dr. Harlan Firminger became head of the department in 1958. With his careful reorganization of the existing facilites, the three activities (laboratory services, research and teaching), were considerably enlarged, especially in the area of anatomical pathology. Even greater expansion was possible in 1964 with the completion of Howard Hall. This facility provided much needed space for the teaching of medical students, as well as laboratory and office space for the faculty.

About 1967 an affiliation was established with the LRVAH. This was possible because the mission of LRVAH was changed from that of a pulmonary disease hospital to that of an acute care hospital. Since that time some of the third and fourth year medical students have received part of their training in Medicine at LRVAH. In support, professional individuals in the Laboratory Service at the Veteran's Hospital gained part-time appointments on the University faculty. This relationship between the two hospitals has continued to develop. For example: residents from both hospitals rotate through the services of either hospital, staff members from the LRVAH regularly teach at the Medical School and members at the Medical School regularly attend conferences and teach at LRVAH. Currently several research projects are underway with the facilities of both institutions contributing to the progress of the projects.

Because of the regionalization in the Veteran's Administration, the Veteran's Hospital at Fort Howard has also developed a relationship with the Department of Pathology. This Laboratory Service is directed by Dr. Abu Fahkruzzaman.

In 1970 Dr. Benjamin F. Trump became chairman of the Department. To facilitate and expand the training of residents in the Department of Pathology, the Clinical Laboratories of the Hospital were put under the stewardship of the Pathology Department. In 1973 the service areas of the department were moved into the north wing of the Hospital, offering better physical facilities. Since his arrival in 1970, Dr. Trump has also greatly expanded the research activities in pathology. A more detailed discussion of the three main areas of activity follows.

Research:

The goal of the research program has always been the understanding of the mechanisms of human disease and the development of new methods for its diagnosis.

Since the late 1950's and 1960's, the biology of neoplasia has been an important area of research. Especially notable in this regard were Dr. Firminger and his group, who studied the relationship of various hormones to the progression of liver tumors in rats induced by the ingestion of carcinogens. A significant phenomenon that they discoved was that chloramphenicol fed to the rats simultaneously with receiving carcinogen almost completely inhibits the formation of tumors.

Since Dr. Trump has assumed the chairmanship large programs have been developed in basic areas of pathology such as the process of neoplasia, cell injury, the inflammatory process, cellular immunology, and immunopathology. Some projects are centered on particular organ systems such as the cardiovascular, renal, or nervous systems. A theme central to many of these investigations is the role that cell membranes play in the pathogenesis of the processes. The variety of facilites available to study biological modalities has increased. These devices include several types of microscopy such as fluorescence and phase, light microscopy and transmission and scanning electron microscopy (Fig. 1), including the supporting functions for processing tissues in considerable quantity. Cell sizers and counters and other instruments for chemistry are also used on a scheduled basis.

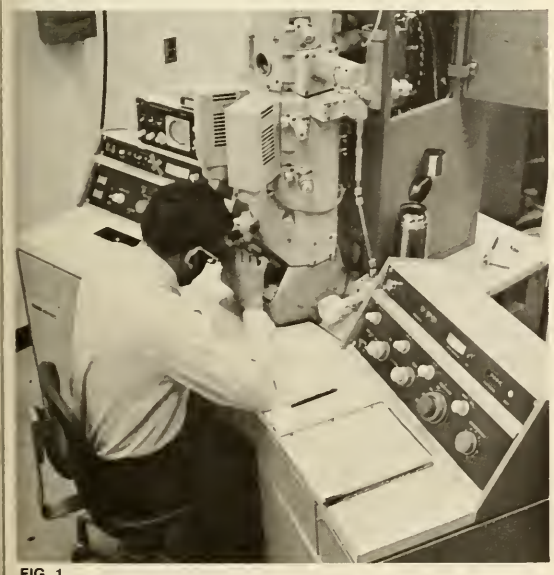

FIG. 1
Dr. Patel tries for 10 angstrom or bust.

Some of the various projects underway will now be surveyed. In the area of carcinogenesis Dr. Trump, in collaboration with Dr. Elizabeth McDowell, Dr. Raymond Jones, and Dr. Lucy Barrett, is engaged in extensive studies of carcinogenesis in several important human target organs such as the breast, bronchus, pancreatic ducts, and colon. These studies involve exposure of human tissues maintained for long periods of time in organ culture to carcinogens as well as xenotransplanted into nude mice. These programs are conducted in collaboration with scientists at the National Cancer Institute and the Cancer Center, Frederick, Maryland.

Another important program, led by Dr. David Hinton, involves studies of environmental pathobiology, including the effects on mammalian systems of compounds such as polychlorinated biphenyl and its conjoiners, and the effects of insecticides including DDT on egg shell calcification in mallard ducks. These environmental studies are important to the community and are being extended toward environmental studies of various vertebrates and invertebrates in the Chesapeake Bay.

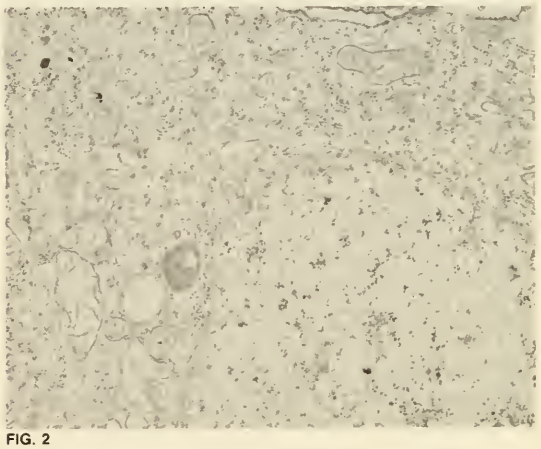

FIG. 2
This is an electron micrograph from the cerebral cortex of a 6-year-old child who developed progressive dementia, blindness and paralysis. The examination by light microscopy showed only "storage disease." This electron micrograph reveals what is interpreted as a neuron (middle of figure) and an astrocyte (left). The stored substance in the cytoplasm of the neuron is ceroid lipofuscin which categorizes the disease into the group originally described by Spielmeyer, Vogt, Batten, Kufs and others.

The pathophysiology of ischemic injury is an ongoing effort of the Department involving studies of ischemia of the heart by Dr. Wolfgang Mergner, of the central nervous system, by Dr. Julio Garcia (Fig 2), of the pancreas by Dr. Jones, and of the kidney by Dr. Trump and Dr. Mary Kahng. These studies hope to identify the key cel-

lular events that determine irreversiblity following ischemia and to design metabolic or pharmacologic interventions to prolong the reversible period or foster recovery. Such studies could be important in the treatment of several human diseases including heart disease, shock, and stroke. Over the past six years, Dr. Trump and his group, in collaboration with Dr. R. Adams Cowley, Director of the Maryland Institute for Emergency Medicine, and Dr. Russell S. Fisher, Professor of Pathology and Chief Medical Examiner for the State of Maryland, have conducted extensive collaborative studies on the cellular pathology of human shock. This has been based on studies of the human using the immediate autopsy techniques mentioned elsewhere in the report as well as parallel experimental models of shock in animals such as the rat and the dog.

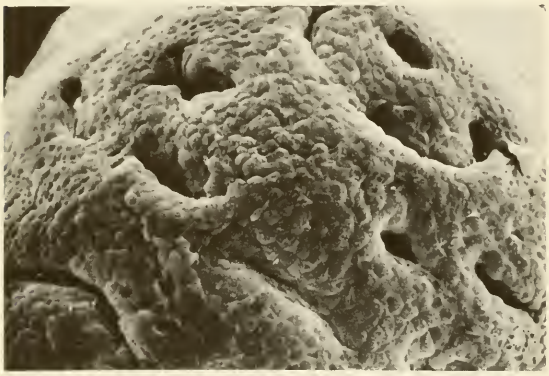

FIG. 3

The exits of the collecting ducts are noted in this scanning electron microscopic view of a renal papilla. The scaly appearance of the surface of the papilla is due to its epithelial cells.

Studies of the correlation between structure and function in the mammalian kidney using scanning electron microscopy, X-ray microanalysis, and other techniques are the research interests of Dr. Bulger and her group (Fig. 3). They have achieved international recognition for their studies in the detailed microanatomy of the nephron in vertebrates and for studies in the experimental pathology of the kidney. Other departmental members engaged in research of the kidney are Drs. Raymond Nagle, Moon Shin and John Sutherland, who have been active in the study of immunopathologic phenomena in various types of glomerulonephritis. A large program concerning renal carcinoma and the pathogenesis of acute renal failure in animals and in man is led by Dr. Trump and includes Drs. Barry Heatfield and Hinton. Concerning renal failure, mercuric chloride is used to injure the animal kidneys, which are compared to human renal biopsies taken at immediate autopsies. These studies are directed toward defining the basic mechanism of renal failure in each of its clinical stages.

X-ray microanalysis and electron diffraction are relatively new methods for studying human diseases and each promises to yield much new information about ion content of tissues as well as providing new diagnostic tools. Dr. Andrew Saladino (Fig. 4), Dr. Kook Kim (Fig 5), Mr. Robert Pendergrass, Ms. Irene Berezesky, and Mr. Barry

FIG. 4

Dr. Saladino (LRVAH) warms up the scanning electron microscope.

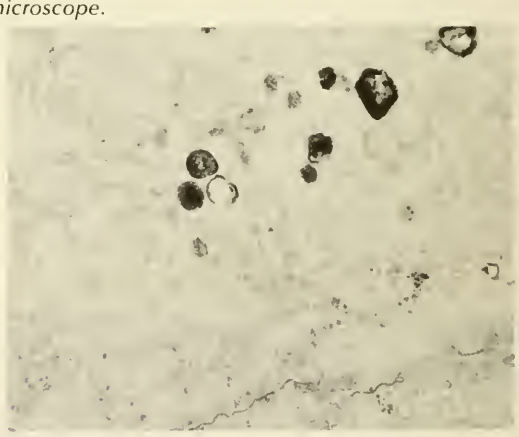

FIG. 5

Calcification of a normal human aortic media begins regularly in middle age and gradually increases with age. It characteristically occurs within membranous vesicles, which may be cellular degradation products. Collagen and elastic fibers do not show calcification. The calcific deposits are dark and rounded and at the top of the photo.

Weavers have been using these techniques to study iron metabolism, especially aspects of the subcellular pathways of ferritin and hemosiderin synthesis, transport, and storage (Fig 6, 7). Recently, Dr. Jon Valigorsky has been engaged in elucidation of iron metabolism following hemorrhage into the aortic wall.

As well as the studies on iron metabolism, many basic studies are being carried out on organelle

pathology including mitochondria, lysosomes and microtubules. In this area Dr. Greta Tyson has achieved recognition for her studies on basic characteristics of microtubule assembly and disassembly and their effects on complex cell processes.

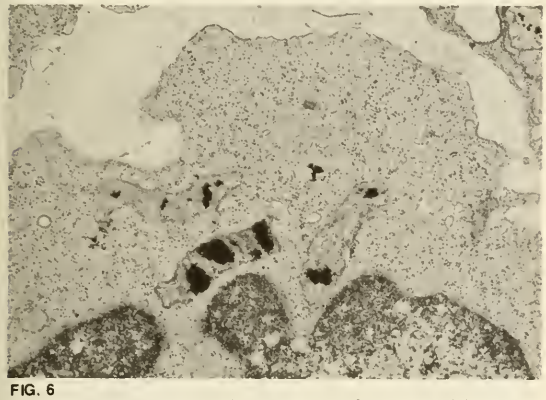

FIG. 6
Electron micrograph of a portion of a normoblast from the bone marrow of a patient of Dr. Rouben Jiji with so-called sideroblastic anemia. In 3 of the mitochondria near the center of the photo are 1 or more large desposits of iron, which are characteristic of many of the normoblasts in this type of anemia.

FIG. 7
This is an energy spectrum derived from radiating one of the 3 large aggregates of iron in the mitochondrion just left of center in figure 6 with a beam of x-rays using a scanning electon microscope having an x-ray probe. Two peaks thought to be significant are labeled Fe (iron) and P (phorphorous). The intramitochondrial deposits may be an iron phosphate.

The important area of immunopathology is represented by Dr. Gardner Middlebrook, Dr. Ronald Anthony and Dr. Zulema Reggiardo. Dr. Anthony is engaged in studies on carcinoembryonic antigens (Fig 8) and Drs. Middlebrook and Reggiardo on various aspects of cellular immunity including immunotherapy of neoplasia and further characterization of the active components of BCG.

Finally, in the area of hepatic disease Dr. Oscar Iseri is conducting an extensive program on the subcellular events occuring in alcoholic hepatitis and events related to the pathogenesis of cirrhosis.

FIG. 8
Immunodiffusion patterns resulting from the diffusion of CEA against a specific antiserum. Wells 1 and 3 contained CEA, undiluted and at 1:500 respectively. Wells 2,6 and 7 contained goat anti-CEA sera. Wells 4 and 5 contained acid extracts of normal colon.

Service:

A broad range of services is available from the Pathology Department.

Anatomic Pathology headed by Dr. Colin Wood has made many developments in the past several years, including many new methods for correlating structure and function, such as the use of electron microscopy in its various forms, electron diffraction, X-ray microanalysis, histo-and cytochemistry, immunofluorescence, cell and organ culture, and new methods for sampling tissue such as the immediate autospy. The Autopsy Service, under the direction of Dr. Mergner, has achieved international prominence by developing improved methods for autopsy study including the immediate autopsy in collaboration with the Maryland Institute for Emergency Medicine. In this technique tissues are obtained within minutes following the patient's death, so that studies involving electron microscopy and biochemistry can be carried out to improve greatly the type of information obtained. Other innovations of the autopsy service include a more rapid type of reporting system, several new conferences with clinical colleagues and the development of a pathology assistant program.

In the area of surgical pathology diagnostic electron microscopy is becoming increasingly important because with this method it is possible to make diagnoses and new correlations hitherto impossible. Already it has achieved great importance in the area of kidney disease and is becoming increasingly important to diagnosis in areas such as certain neoplasias, hepatic disease, and skin disease. This is often coupled with immunofluorescence studies by which antigens and other immune reactants can be localized in relation to altered cell and tissue structure.

In the area of neuropathology Dr. Garcia has organized an outstanding neuropathology unit which has extensive interactions with Neurology and Neurosurgery. In addition to the classic methods used in neuropathology, electron microscopy and cytochemistry, particularly in the study of brain biopsies and muscle biopsies, are becoming increasingly important (Fig 9).

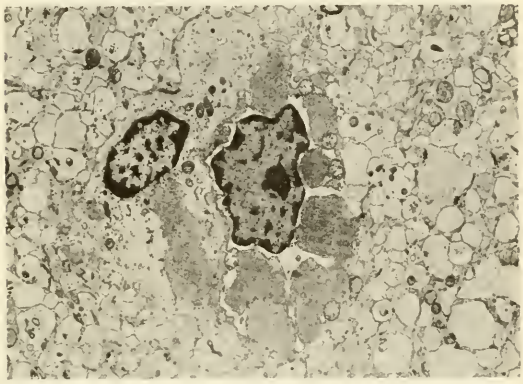

FIG. 9
This is an example of the knowledge obtained from experimental work on stroke. The cell in this figure is a neuron from the cerebral cortex of the cat whose middle cerbral artery had been occluded approximately one hour before. The mitochondria show slight swelling as the only morphologic change resulting from the ischemia.

Cytopathology is also profiting from the expansion of knowledge in anatomic pathology and presently Dr. Joella Pyeatte, its director, is engaged in studies correlating cytologic phenomena as seen in classic cytologic smears with information obtained from newer classifications of tumors also using ultrastructural criteria.

Other important new approaches in anatomic pathology will include biochemical analyses of tissue components to correlate with structural alterations. Among the more important of these may be the assay of hormone binding sites to establish hormone dependency in tumors such as those of the breast and the prostate gland. Eventually this may become part of the normal surgical pathology workup. Other organ-oriented programs are needed and accordingly Dr. Iseri (Fig 10), primarily located at the LRVAH, has developed a hepatic and gastrointestinal pathology program. Dr. Colin Wood (Fig 11) has developed a dermatopathology program, and Drs. Nagle, Shin and Mary Hall-Craggs, a kidney pathology program. Studies of vascular disease are under the direction of Dr. Mergner, who is engaged in extensive research on this subject.

The Clinical Laboratories have considerably increased the number of tests offered. The opening of the north wing of the Hospital helped make this possible. With this opening a sizeable amount of new equipment was also made available through a bond issue from the State. Whereas in the early 1960's a sizeable number of tests were sent to other reference laboratories for performance, this is now an unusual event.

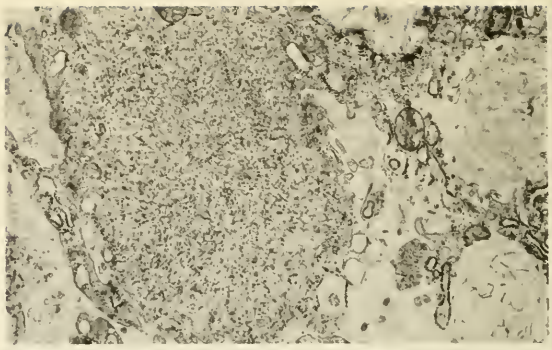

FIG. 10
From an electron micrograph of a liver biopsy of a patient with alcoholic hepatitis. Intertwining fibrils of alcoholic hyalin appear in a partially disrupted hepatocyte.

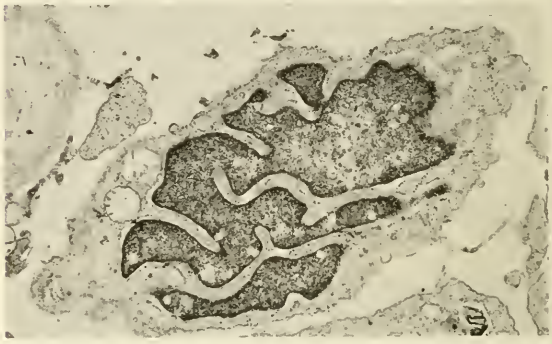

FIG. 11
This electron micrograph illustrates a dermal mononuclear cell with a convoluted nucleus. Such cells (often called Lutzner cells) permit the recognition of early lesions of mycosis fungoides.

In Clinical Chemistry, under Col. Edward C. Knoblock, a recent example of test improvement is the advent of the centrifugal fast analyzer. The concept was develped into a working machine at the Atomic Energy Commission Laboratories in Oak Ridge, Tennessee. Three corporations have production models and some of the field testing for the model of one of the corporations occurred in the Clinical Chemistry Laboratory at the University of Maryland Hospital. Much of this testing was directed by Dr. Henry Nipper. Within a spinning rotor in the analyzer the optical densities of the reactions of 16 samples are sequentially recorded at high speed, and from the changes in optical density per unit time the concentration of the analyte can be determined. Because the results are recorded so rapidly a computer is required to calculate the final result. The device has considerable potential for analysis in that the rate of changes of

optical density is rather characteristic for each chemical reaction. Presently the determination of serum enzymes is an important application.

Some other of the important tests being done in Clinical Chemistry are: several tests for drug screening and toxicology; ligand assays such as serum digoxin, folate, vitamin B12, and HBs Ag.

Under the direction of Dr. Valigorsky and Dr. Ferdinand Rodriquez at LRVAH, the tests performed in the Hematology Laboratory have been expanded. The samples of bone marrow from many patients are examined by electron microscopy in addition to being studied using several histochemical techniques (Fig 12). This type of examination has enabled a more critical assessment of the anemias associated with sideroblasts and various types of leukemias. Also available from hematology is a test for plasma viscosity, which is especially helpful in following the progress of certain dysproteinemias, in which the level of plasma proteins may be inordinately high.

FIG. 12
Dr. Lindado teaches a medical technology student about the morphology of blood cells.

In Clinical Immunology Dr. Anthony has recently made available a number of tests which assess the immune status of a patient. These include various tests concerning humoral immunity such as measuring titres of antibodies against several infectious agents and tests which assess cellular immunity such as identifying B and T lymphocytes in blood. After considerable developmental work Dr. Anthony and Mr. Ken Sosnowski (a graduate student working with Dr. Anthony) have evolved a passive hemagglutination test which is able to detect nanogram quantities of carcinoembryonic antigen.

Dr. Andrew Smith in Clinical Microbiology has improved the yield of positive blood cultures. This was made possible with the use of a device which automatically samples the atmosphere of cultures (Fig. 13). By injecting the fluid to be cultured into vials containing ^{14}C labeled substrates, the evolution of CO_2 can be monitored and growth detected. This not only has accelrated the detection of bacterial growth, it also has increased the number of positive cultures of significant organisms. Definitive diagnosis of fungi causing infection is also a notable capability in microbiology.

FIG. 13
Ms. Jacqueline Matthews gets ready to check readings on the Bactec, which continues to count away at night .

A cytogenetics service (Dr. Rasmussen) performs analysis of karyograms with capability for staining for banding of chromosomes by the giemsa or fluorescent methods.

The Blood Bank under the direction of Dr. R. Ben Dawson processes blood and its components for about 22,000 transfusions per year. In addition to the many transfusions given in various services throughout the Hospital, a large demand for whole blood or its various components is presented by the Maryland Institute for Emergency Medicine, the Division of Thoracic Surgery, and the Baltimore Center for Cancer Research (Fig 14).

FIG. 14
Ms. Nena Savell readies some platelets for a busy Saturday in the Blood Bank.

One especially significant capability which has been achieved on a limited scale is the availability of frozen red cells. The use of frozen red cells in transfusion is advantageous in that the risk of post-transfusion hepatitis is virtually eliminated and the exposure to histocompatibility antigens from leukocytes is greatly reduced.

FIG. 15
A monster in Clinical Chemistry eats up specimens at an alarming rate.

The Clinical Laboratories have become highly automated with gains in precision and effciency (Fig 15). This increase in automation has led to the problem that whereas accurate data are generated at a rapid rate, their dissemination to the physicians has not kept pace. To rectify this the laboratories, in conjunction with other areas of the Hospital, are preparing a program for automated data processing. It is intended to have data input from the laboratory on line and in real time with the data reporting components. This will enable rapid answering of inquiries, since as test results are performed they will be easily available for recall from the central processing unit of the computer. In addition, transcription errors will be greatly reduced.

Teaching

The educational effort of the department has always been an important concern. The members of the department have always taken this most seriously. This effort has had two significant results: appreciation by 3rd and 4th year students for the substantive knowledge of disease they obtain, and a high level of achievement by the medical students on the National Board examinations.

The course in pathology has a variety of teaching sessions which includes museum case studies derived from autopsies, review of current material from autopsies, slide and gross study, practical work in the common manual laboratory procedures, work on literary or original projects, and of course lectures. The museum case study is designed to illustrate a disease entity from its inception to its end using the clinical history and the autopsy findings. In addition, it allows the student to see many of the problems a patient may have rather than only one organ with one disease process. Each student is required to demonstrate proficiency in doing cell counts and other laboratory procedures which he might have to perform in subsequent training or practice (Fig. 16). Each student has an opportunity to work out a karyogram unknown, perform an office type pregnancy test and observe many demonstrations of various laboratory procedures.

FIG. 16
Martin Kroll (a second year medical student) performs a test for occult blood in one of the exercises concerning laboratory procedures.

This method of teaching is possible because of a large visiting faculty, in addition to those in-house. The visiting group are pathologists in the State who each spend an afternoon every week or biweekly involved in many of the teaching sessions mentioned above.

Over the years the medical students have had many opportunities to participate in the activities of the department either in its service areas or through original reserach projects in conjunction with a faculty member. An example is that of one of our current faculty members, Dr. Valigorsky, who spent one year out of school during a research fellowship; subsequent to graduation he took his residency in pathology and is now an Assistant Professor. Currently some students become involved with educational activities of the department during their first year and continue with such activities throughout their time in medical school.

Three other important areas of education and training maintained by the department are those of the residency, the graduate program, and the School of Medical Technology (Fig. 17). The residency is approved for eligibility to take both the anatomical and clinical pathology components of

the examination for certification by the American Board of Pathology. Most of the residents have successfully achieved certification in both. There is also approval in neuropathology, dermatopathology, hematology and blood banking. Especially valuable to the residents is a continuing illustrated demonstration of a broad spectrum of diseases and pathological processes in neuropathology (Dr. Garcia).

FIG. 17
The medical technology students practice procedures in a bacteriology laboratory.

A graduate program is available for achieving a Ph.D. or a Master's degree in pathology. Candidates take most of their course work at the Baltimore Campus and perform their research using the facilities of the department. Forty-nine candidates are actively enrolled in the graduate program. It is hoped that these graduates will help to fill a need for individuals educated in this way in hospital laboratories, medical schools and industry. The School of Medical Technology, directed by Dr. Jason Masters, offers a B.S. or M.S. degree in Medical Technology. At the bachelor's level the students spend six months of their fourth year in didactic work and six months rotating through the sections of the Clinical Laboratories.

Problems for the Future

In the realm of medical education at Maryland one important problem has been the difficulty for faculty and students to become acquainted due to the large student body. Enrollment has increased steadily, and will peak at about 200 students. The opening of the new facilities in the Howard Hall addition and the new building to the west of it may help solve this problem by allowing closer interaction between faculty and students. More generally a continuing need exists to insure that the medical students receive a first hand view of new information and methodology. The purpose is not to make them technicians or pathologists, but to insure that they understand the constraints and idiosyncrasies which are often introduced with new technology.

In the area of service these problems come to mind. One is the requirement continually to broaden the number of available tests as these tests are proven, and yet to maintain costs at a reasonable level as governmental limitations increase. One corollary of this is the need for increasingly expensive capital equipment at a time when funds for capital equipment are increasingly difficult to obtain. In the Clinical Laboratories great quantities of accurate data are generated rapidly. As mentioned above it is necessary to disseminate these data to the physicians who make decisions based on them. The present rate of flow of information at University Hospital can be improved with data processing systems, which have advanced to a high level of capability to solve this problem.

On a large scale the problem of rapidly collating medical information is one that the University of Maryland Hospital must solve in the near future. This is the case not only because of the needs of good practice, but also because of the need to respond to the increasing demands for such information by monitoring agencies at all levels of government.

Finally, in the realm of research and development as in all academic fields, the need to achieve continuing support is a significant problem in the face of shrinking resources.

Despite these problems I believe the Department of Pathology will continue at its present high level of achievement because of the efforts of its many dedicated people as well as the ongoing and increasing support from the Medical School, the State, the NIH, and other outside agencies.

Dr. Rasmussen is Professor of Pathology and Director Clinical Laboratories, University of Maryland Hospital

A Note of Thanks . . .

to M's Greta Warren, the staff and patients of 2-G and 2-F Psychiatric Units for their assistance in preparing the November issue of *The Bulletin* for mailing. Over 5,000 copies were efficiently and promptly hand-stuffed in envelopes and tied in bundles.

The staffs of *The Bulletin* and the Medical Alumni Association are very grateful to 2-G and 2-F for their assistance.

Dean's Message

John M. Dennis, M.D.

The School of Medicine has taken two major steps towards redressing the direction and emphasis of its educational programs. The first of these is establishment of a Primary Care Program designed to complement and/or supplement some aspects of the already established Family Medicine Program. The second is the establishment of an Area Health Education Center.

In the past decade or so, the health planning community, at the state, federal and local levels have been wrestling with the problem of the inadequate availability of physicians and health services in some areas. With one notable exception—the establishment of a Family Medicine Program at the University of Maryland —most of the efforts to date have assumed that the problem of availability could be solved by merely increasing the aggregate number of physicians in the state. Thus, enrollments in the Medical School increases and will continue to do so for the next two or three years. Yet national trends seem to indicate that even though a very favorable physician/patient ratio will soon be established, the availability of primary care service (however defined) has not and perhaps will not improve in a parallel fashion. This observation, if correct, raises some serious problems with the state's health care programs.

Most traditional medical schools, of which this is one, are located in the urban tertiary care centers; the academic medical centers. The curricula of these schools have tended to emphasize the practice patterns of the center and its specialty-oriented faculty. Thus, it is not surprising that the school's products have reflected the training provided. To alter this trend, to redirect the students from a specialty to a primary care career, requires several shifts in the educational program. There must be, as a significant part of the curriculum, an emphasis on the methods and patterns of primary care. This in turn requires the establishment of at least two new emphases: role models in primary care practice and model delivery systems. The former is being accomplished by the inclusion of Family Medicine and Primary Care into the undergraduate training; the latter by the development of an Area Health Education Center.

Area Health Education Centers are designed to serve at least four purposes: 1) to provide health professional students (medical students and house staff, nurse and pharmacist-practitioners and dentists) with a model delivery system in which primary care is taught. These are located in areas away from the academic medical centers and provide first contact admission services. 2) to provide the community with a health service resource, including the primary care rendered during the educational process as well as on-going, continuing and in-service education for the Area professionals as well as consultant service and readily accessible referral service for patients requiring tertiary care. 3) to provide necessary research in health care delivery system models, and 4) to provide a means of recruiting physicians and other health professionls in areas currently designated as medically under-served and to delivery of primary rather than specialty care.

John M. Dennis

The Relationship of Scleroderma and Pulmonary Tuberculosis

P. Jan Geiseler, M.D.

ABSTRACT

In 45 patients with systemic scleroderma none developed superimposed pulmonary tuberculosis during the course of their treatment and observation. The tuberculin skin reaction was positive in 40% of those tested. A review of the American and European literature disclosed little evidence for a definite association between scleroderma and tuberculosis indicating that pulmonary tuberculosis is activated infrequently during the advanced stages of scleroderma, which often includes the enhancement effect of steroid therapy.

During a seminar discussion of several patients with systemic scleroderma with pulmonary involvement, we were struck by the absence of pulmonary tuberculosis, in spite of positive tuberculin skin reaction, fibrotic pulmonary lesions, and the use of systemic steroids in treatment, all of which might favor tuberculous infection. This prompted us to review the subject and survey retrospectively all available case records for association of scleroderma and pulmonary tuberculosis.

METHODS

Survey of case records: The hospital records of patients with a clinical diagnosis of systemic scleroderma made at the University of Maryland and Maryland General Hospitals, Baltimore, between 1950 and 1972 were examined. Of the total of 69 charts available for study, only 45 cases fulfilled the specific criteria of, either: *1) confirmed (positive) systemic scleroderma,* based on all three conditions of (a) characteristic manifestations of the disease, with typical skin changes[1-3], (b) visceral involvement of lungs, gastrointestinal tract, etc., (c) histologic confirmation of skin changes by biopsy or by postmortem findings; or 2) *probable diagnosis of systemic scleroderma,* based on any two of the aforementioned criteria.

Evidence of tuberculosis was sought, based on the medical history, physical findings, sputum smear, culture, chest roentgenogram and positive tuberculin skin reactivity (induration of at least 10 mm. to intermediate strength PPD).

RESULTS

Analysis of case records: Study of hospital and subsequent follow-up records was difficult because of incomplete data in the charts and the loss of many patients to follow-up after initial hospitalization. However, no active pulmonary tuberculous disease was confirmed in any of the 45 patients with systemic scleroderma. Only 20 patients had a recorded tuberculin skin reaction which was positive in eight of these patients (40%) (Table I). Twenty of the 45 patients had roentgenographic evidence of pulmonary disease, mostly interstitial in pattern. Only 12 of these had tuberculin applied, five were positive. Two patients had findings that were suspicious of tuberculosis without confirmation; a fibrotic infiltrate in the right upper lobe of a 66 year old man suggested healed tuberculosis, but the tuberculin reaction was unrecorded. A 39 year old woman showed fibrosis of the right upper lobe and a positive tuberculin reaction but no evidence of interstitial disease.

Follow-up data were incomplete in most of the cases. Of the nine patients that died (Figure 1), postmortem examination performed in five, confirmed the clinical diagnosis. Twenty-three patients were observed for less than one year. Among these was a 52 year old negro man with silicosis and severe pulmonary insufficiency, a positive tuberculin skin test and characteristic histologic skin changes of scleroderma. His course was rapidly fatal; there was no evidence of tuberculosis at postmortem examination. Of the positive tuberculin reactors, only a 49 year old male had received steroids; no evidence of tuberculosis at necropsy was noted. Only one patient with a positive PPD received isoniazid.

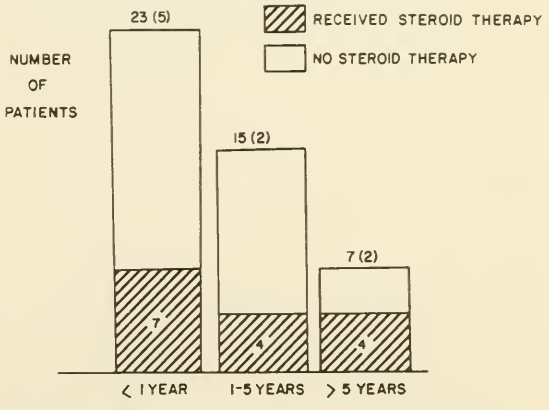

FIGURE 1- CLINICAL FOLLOW-UP OF 45 PATIENTS WITH SYSTEMIC SCLERODERMA
NUMBERS IN PARENTHESES INDICATE DECEASED PATIENTS

REVIEW OF LITERATURE

In several excellent reviews of systemic scleroderma (progressive systemic sclerosis), including two monographs, in the English medical press[1-13], there is little reference to the relationship of the disease and infection. Bronchopneumonia and aspiration pneumonia in patients with scleroderma and severe lung or esophageal involvement occurs frequently as a terminal event. A standard medical text[14] includes tuberculosis in the differential diagnosis of complicating infections of scleroderma lung disease.

All available well-documented series of cases of systemic scleroderma were analyzed, including reference of case reports recorded in the European and Soviet press cited in Index Medicus from 1950-1973 (see Table II).

In most comprehensive reviews, no mention of pulmonary tuberculosis nor of the status of the tuberculin skin reaction is specifically included. Sackner[3] observed four instances of pulmonary tuberculosis among 65 patients with scleroderma. Whether their tuberculosis was active or arrested, confirmed by histologic or bacteriologic findings, or existed prior to the onset of scleroderma is not stated. In his monograph, the literature is reviewed and 10 cases of active tuberculosis were found among 275 necropsy reviews, but no further data are given. In 27 patients with scleroderma, Rodnan[7] reported a case of unsuspected miliary tuberculosis following large doses of corticosteroids; there was no autopsy confirmation. In Stava's series of 65 patients[11], three were thought to have tuberculous complication based solely upon radiologic interpretation. Further, he acknowledges that this could actually represent scleroderma lung disease. At a recent Clinicopathological Conference at Massachusetts General Hospital, a case with systemic scleroderma, miliary tuberculosis and multiple tuberculomas of the central nervous system was presented[15]. This generalized tuberculous infection was clinically unsuspected. In the world literature, several reports are to be found of a questionable clinical relationship between the two diseases. Ozerova[16] reported the findings of a patient who was treated with anti-tuberculous drugs for right apical "infiltrates", who later developed a Calcinosis-Raynaud's phenomenon-Sclerodactylia-Telangiectasia (CRST) type syndrome. No results of sputum examination, tuberculin skin reactivity or histologic confirmation of scleroderma are included. Oleneva[17] reported two patients with scleroderma among 184 cases with pulmonary tuberculosis. One of these was an 18 year old patient with a past history of childhood tuberculosis who developed a Felty syndrome. The other patient also had been treated for childhood tuberculosis and developed scleroderma in adulthood, without recurrence of tuberculosis in spite of treatment with steroids. Frostad[18] reported one patient with a past history of tuberculosis who developed generalized scleroderma, and recurrence of cavitary pulmonary tuberculosis after treatment with steroids, without mention of bacteriologic or histologic confirmation. Zimmerman[19] reported a patient with histologically confirmed progressive systemic sclerosis, who, one year later, developed generalized lymphadenopathy, positive Sabin-Feldman test for toxoplasmosis, and characteristic findings of miliary tuberculosis. Langer[20] reported a patient with scleroderma, treated with prednisone who developed confluent infiltrates and cavitary lung lesions several years later. The tuberculin skin reaction was negative and results of sputum examinations are not given. This patient improved with triple antituberculous therapy and prednisone.

DISCUSSION

Scleroderma is a relatively rare disease with an average annual incidence of about 2.7 new cases per million[21]. Only 35% of patients survive for seven years; prognosis is poor during the first year, and particularly in males, negroes, patients over 45 years of age with renal, cardiac or lung involvement[22].

Tuberculosis remains an important illness among poor persons who reside in overcrowded urban centers in the United States and elsewhere. In the United States in 1967, the new active case rate was 23.1 per 100,000 population, mostly in patients aged 45 or more.

Whether tuberculosis or scleroderma predisposes to each other is unknown. Our data and patient sample are inadequate to answer the question. The tuberculous infection rate is 4.4% in Navy recruits from metropolitan areas. The tuberculin reactor incidence among predominantly non-white Navy recruits in 17%[23]. Our group of scleroderma patients tested for skin reactivity showed a rate of 40%. Most patients were 45 years or older which typifies the group with highest tuberculin reactivity. We could not compare our rate with other series because of insufficient data. Hence, this issue is unclear.

Scleroderma is a disorder of unknown etiology with little evidence to support an infectious or immunopathologic cause[24, 25]. Acid-fast bacilli have been postulated as factors in pathogenesis; Cantwell[26] reported the isolation of unclassified

acid-fast bacilli from macerates of dermis, but the type of gross or histologic dermal inflammatory changes resulting from these microoganisms was not described. Little valid data support the mycobacterial etiology of scleroderma[27]. Conversely, we are unable to refute or confirm that scleroderma per se reactivates a latent tuberculosis infection. None of our patients treated with steroids developed active tuberculosis. Supporting data for this concept, gleaned from the medical literature, are inconclusive. An important consideration is whether chemoprophylaxis for tuberculosis is indicated in scleroderma patients with positive tuberculin reactivity. The National Tuberculosis and Respiratory Disease Association specifically included silicosis as one of the special clinical situations in which isoniazid chemoprophylaxis is indicated[28], considering the frequent complication of pulmonary tuberculosis in patients with silicosis[29]. One of our patients with silicosis and scleroderma had a positive tuberculin reaction, but did not receive INH or steroids. No evidence of active tuberculosis was found on postmortem examination. From our data and the review of the literature, we could not find evidence to support INH prophylaxis in such patients other than the special clinical situations included in the statement on preventive treatment of tuberculosis. It is important to note, though, that when tuberculosis occurs in patients with scleroderma, particularly when receiving steroids, it may be clinically undiagnosed with a fulminant course[7,15,19]. Aspiration pneumonia and broncho pneumonia are terminal complications in patients with advanced scleroderma with visceral involvement; this was found in our series. Thiers[30], in an anecdotal report, stated that tuberculosis was a frequent cause of death in scleroderma in

TABLE I
TUBERCULIN REACTION OF 45 PATIENTS WITH SYSTEMIC SCLERODERMA

Diagnosis of Scleroderma (Clinical-pathological)	Tuberculin Reaction						Total
	15 Males			30 Females			
	Pos.	Neg.	No Record	Pos.	Neg.	No Record	
Positive	4	3	3	4	8	9	31
Probable	0	1	4	0	0	9	14
Total	4	4	7	4	8	18	45

(A positive reaction implies 10 mm. or greater induration)

TABLE II
SUMMARY OF LITERATURE ON CASES OF SYSTEMIC SCLERODERMA COMPLICATED WITH ACTIVE TUBERCULOSIS

Authors (reference)	Number of Patients	Active Tbc.
Sackner[3]	65	4
Leinwand[5]	150	0*
Farmer[6]	271	0
Rodman[7]	27	1
Barnett[8]	61	0
Masi[9]	53	0
Piper[10]	31	0
Stava[11]	65	3
Bennett[12]	67	0
Bassi[13]	50	1
Miscellaneous case reports[15-20]	7	7

* 0 = No mention or evidence of tbc. in the series reported.

the pre-antibiotic era. Clinical rather than confirmatory bacteriologic or histologic data served as basis for that report. In summary, no conclusive evidence could be found for a clinical relationship between systemic scleroderma and pulmonary tuberculosis other than random association.

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Ed. Note: Dr. Geiseler at the time of the writing of this article was Chief Resident and Associate in Medicine, Department of Medicine, University of Maryland Hospital.

ON BEING AN INQUISITIVE PHYSICIAN

Presented at the 100th Anniversary Banquet of the Medical Alumni Association, May, 1975.

John C. Krantz, Jr., Ph.D.

It is always a pleasure to speak to young people, for you have in your possession one of life's greatest treasures, the capital of many unused years ahead. And tonight you join this venerable Alumni Association on its 100th birthday. It is an august association with a noble heritage. I wish to speak to you about the inquisitive physician.

When Benjamin Franklin was in England the Parliament was composed of three estates: the Lords Common, the Lords Noble and the Lords Temporal. Sir Edmund Burke, pointing to the reporters in the gallery, the gentlemen of the press, referred to these men as the fourth estate, probably destined to play as great a part in the history of mankind as any of the other three. They were to carry the news of empire to the distant places of the earth. Burke was unmindful of the fact that there was in England in the person of Benjamin Franklin, a prototype, and exemplar of the new estate, the fifth estate, men of science, architects of progress, who were destined to remold the character of man's life upon this planet. What was there about the intellect of Franklin, which caused the people of England to declare, that when Franklin died an American University with all of its schools closed its doors? And the French affirmed that when Franklin died, an American library, with all of its books, was closed.

There were four facets to the mind of Benjamin Franklin: the simplicity to wonder, the ability to question, the power to generalize and the capacity to apply. As a member of the fifth estate he broke through the frontiers of knowledge and achieved discovery, the increment of progress—the differential coefficient of man's curve of knowledge.

Lowell expressed the spirit and service of the fifth estate, men of science—when he penned these inspiring lines:

> New occasions teach new duties,
> Time makes ancient good uncouth.
> He must onward still and upward
> Who would keep abrest of truth.

Rudyard Kipling characterized that fine art of critical thinking when he penned:

> I have six faithful, serving men
> That serve me till I die,
> Their names are who, and what, and when,
> And how, and where and why.

We are in merry England and the year is 1775. We are at a meeting of the Lunar Society, one of the most erudite societies in the kingdom. Among its members were Erasmus Darwin, grandfather of the immortal Charles Darwin; James Watt, who discovered the power of steam; Joseph Priestley, who discovered oxygen and nitrous oxide; and William Withering, the "flower of English physicians." Franklin visited the Lunar Society and sought the advice of Dr. William Withering regarding his urinary calculi.

The principal of Brasen Nose College was seriously ill with dropsy. The standard treatments of the day had failed. The herb concoction of Mrs. Hutton of Shropshire was tried and produced dramatic results. This information reached Withering, who had the simplicity to wonder about it. He journeyed to the cottage of Mrs. Hutton and for a few golden sovereigns secured the formula for the herb concoction of twenty ingredients. He carefully tested on turkeys the activity of the various herbs, ultimately he concluded that it was the leaf of the purple foxglove that was responsible for the beneficial results. Those who are physicians in this audience can hear him say, "With this drug we can regulate the pulse at will." Little did he realize the importance of that timeless paper published in 1785, "The Foxglove and an Account of its Medical Properties." Withering, the busy clinician, Withering, the connoisseur in mineralogy, would have been lost to posterity, and the same tomb which covers his body would have covered his fame also, if he had not had the simplicity to wonder about and the ability to question the value of an old herb concoction.

More than a century has passed and Dr. Frederick G. Banting was serving as a surgeon with the Canadian Expeditionary forces in World War I. He was wounded at the battle of Cambrai and received the Military Cross for valorous conduct. In 1920 Banting was back in London, Ontario in the process of building a medical practice. Patients were few and Banting had much time to peruse the journals. In *Surgery, Gynecology and Obsterics* an article by Moses Barron intrigued him. Barron pointed out the analogy between the degenerative changes which follow the experimental ligation of the pancreatic duct and the blockage of the duct by gallstones. Through the scintillating intellect of Banting flashed the

idea of ligating the pancreatic duct, allowing degeneration of the zymogeneous tissue to occur and then extracting the islet tissue for its antidiabetic substance.

This inquisitive physician could not sleep that night. He took the problem to his alma mater the University of Toronto and presented it to the distinguished physiologist Dr. J. J. R. Macleod. Reluctantly he was given space in Macleod's laboratory and the assistance of a student Charles H. Best.

Work was begun in May 1921. After developing a procedure for the ligation the degenerative process was allowed to proceed for several weeks. In July the first islet tissue extract was prepared and injected into a depancreatized dog. The blood sugar level fell from 200 to 110. The die was cast. Soon this extract called insulin would be purified and make its way to the metabolic clinics of the world and diabetes frequently a fatal disease had been reduced to a mere inconvenience. Millions of lives have been snatched from the grave because Banting the inquisitive doctor had the simplicity to wonder.

George R. Minot, a Harvard trained physician and a descendent of several distinguished medical men of New England,was at a youthful age professor of medicine at Harvard. He exhibited marked ability to search for the answers of baffling questions in diagnosis. His attention was directed to blood dyscrasias, particularly pernicious anemia. He read about the work of William H. Wipple of the University of Rochester. Whipple showed that iron was effective in treating secondary anemia in dogs if it was accompanied in the diet with substances containing protein molecules essential to the structure of hemoglobin. Milk and egg protein were poor supplements. Beef muscle was better but liver was dramatically superb for the purpose. Minot wondered whether or not liver contained the antipernicious anemia principle. The brain of the inquisitive doctor was at work.

In 1926 with his associate W.P. Murphy, Minot treated 45 patients with pernicious anemia with massive quantities of liver. The results were overwhelmingly conclusive, the average red cell count had risen from 1.5 to 4.5 million in 4 to 6 months of treatment. And an invariable fatal disease was now able to be controlled with an item of diet. Liver extracts followed and ultimately vitamin B12, a crystalline red compound containing the metal cobalt was shown to be the anti-pernicious anemia principle.

Many honors were showered upon George Minot including the Nobel Prize. He continued throughout his life as an insatiable investigator. Over 100 students trained by him became leaders in medical education and research. For more than 4 decades he had fought a running battle with diabetes and with the aid of Banting and Best's insulin, achieved a victory. But the ubiquitous enemy of man, atheriosclerosis was lying in ambush, noted its strategic attacks, struck the blow: and a gallant soldier in the battle for humanity died on February 5, 1950; inquisitive, majestic and dauntless to the end.

The year 1929 was a great one for the human race. It was the end of the hysterical twenties—the age of the flivver and the flapper. Two years before, Lindberg had electrified the world with his solo flight across the Atlantic. It was in this year that Alexander Fleming discovered the presence of the mold *penicillium notatum* on a dish containing staphylococcus aureus in a culture media prevented the growth of the bacteria. It occured to him that molds might produce a substance inimical to the growth of bacteria. He made extracts of the mold-growth material and injected them into mice infected with pneumococci, staphylococci and streptococci, and he was able to save their lives. The experiment of Alexander Fleming reminds one of those words of Louis Pasteur, "In the field of observation, chance only favors that mind which is prepared." Fleming turned to the medical profession and said, "Gentlemen, I have a drug made from a mold that may be useful in the cure of infectious disease." They turned a deaf ear to him. A decade passed.

Dunkirk was behind the British, and Churchill had declared that the Battle of Britain was about to begin. It was a foggy, cloudy, damp day in February, 1940 that a British bobby, Albert Alexander who had been scratched on the face while pruning rose bushes, went to Radcliffe Hospital in Oxford with a staphylococcus aureus septicemia. The whole gamut of sulfonamide drugs was tried, but he got progressively worse. In the same hospital, Chain and Florey were repeating the experiment of Alexander Fleming. They injected their penicillin extract into the British bobby and his fever dropped precipitously. He appeared to be getting well but they were out of the drug and Albert Alexander died. These astute workers saved the urine from the now dead British police officer and extracted from it penicillin, with which a few days later they saved the life of a boy who had a septicemia resulting from an infected hip. The cure was dramatic. The evidence was overwhelming that these British workers had obtained a drug useful in the treatment of infectious diseases.

Soon penicillin was made by the pharmaceutical manufacturers of this country and placed in the hands of our Armed Forces, and then given to the civilian population. After thirty-five years we look back and see that for the first time on this planet, man has an anti-infective drug useful against many deadly organisms, and which is without any marked toxicity to the human being.

In closing, go with me, if you will, to the great state of California. We are traveling along the great highway that leads to the capital, Sacramento. The Sierra mountains are to our left, silhouetted against a pearl grey sky. As we approach the capitol building, the caption over the door engrosses our imagination: "Give me men to match these mountains." What medicine so eagerly and urgently needs are the inquisitive physicians with the simplicity to wonder to match the challenging era in which you are called upon to serve.

Ed. Note: Dr. Krantz is Professor Emeritus in the Department of Pharmacology, University of Maryland, School of Medicine.

Meetings and Greetings

Members of the University of Maryland Medical School Alumni Association attended a luncheon on Thursday, September 25, 1975 at the Statler-Hilton Hotel in Washington in conjunction with the annual meeting of the Medical Society of D.C.

Dr. James A. Roberts, President-Elect of the Medical Alumni Association, was responsible for the arrangements and the highlight of the luncheon was the guest speaker, Dr. Theodore E. Woodward, Head of the Department of Medicine at the University of Maryland School of Medicine, whose topic was "The Medical School-Past and Present."

• • •

The Mediterranean Center at the Doral On-The-Sea was scene of the Cocktail Reception sponsored by the Medical Alumni Association on Monday evening, November 17, 1975 held in conjunction with the Southern Medical Association's 69th Annual Scientific Meeting in Miami Beach.

The reception was hosted by Dr. Joseph Nataro (1925) and assisted by Dr. Robert T. Singleton (1954) representing the Board of Directors and Mrs. Jean D. Goral, Executive Administrator of the Alumni Association. A number of alumni were present from the southern region, as well as active and retired alumni residing in the Miami area.

PRESIDENT'S MESSAGE

William H. Mosberg, Jr., M.D.

The two questions asked most frequently at the Medical Alumni Office relate to the activities planned for alumni reunions in the spring of this year, and to the current status of the Davidge Hall Restoration Fund. The following is an attempt to answer both of these questions.

In years gone by, it has been customary for the Medical Alumni Reception and Banquet to be held in the evening and preceded earlier the same day by the annual business meeting and scientific sessions of the Medical Alumni Association. In the past few years, this has been preceded the evening before Alumni Day by a reception at Davidge Hall. The latter function, lasting from about 6:00 p.m. until 11:00 p.m., has been a delightful affair, much enjoyed by all who attended. Last year, the annual reception and banquet was held at the Hunt Valley Inn and the parking and banquet facilities were such that it was unanimously agreed that the Hunt Valley Inn would again in 1976 be the site of the reception and banquet. Because of a problem with availability of facilities, the order of these two events has been reversed this year. The annual reception and banquet will be held beginning at 6:00 p.m. at the Hunt Valley Inn on Wednesday, June 2, 1976. The annual alumni day business meeting and scientific sessions will begin at 10:00 a.m. at Davidge Hall on Thursday, June 3, 1976, with registration beginning at 9:00 a.m. This will be followed by a complimentary luncheon for members of the Medical Alumni Association at 1:00 p.m. at the Holiday Inn (just down the street from Davidge Hall). Between 6:00 and 11:00 p.m. on Thursday, June 3, there will be a reception—cocktail party at Davidge Hall for members of the Medical Alumni Association and wives (or husbands). Last year, the attendance at the annual reception and banquet somewhat exceeded expectations and, with a number of alumni arriving who had not made advance reservations, there was some question as to whether we would be able to accommodate all of them. Tentative plans for this year include the possibility of an interesting and provocative speaker who may possibly attract an even greater attendance. We must urge each of you to make your advance reservations to attend the annual reception and banquet, and we must warn you that there is a possibility that we may not be able to accommodate you if you have not made such reservations. The scientific program at Davidge Hall on the morning of Thursday, June 3rd, in keeping with the bicentennial atmosphere, will embrace a medical historical theme. It seems inevitable that the program will have universal appeal to all alumni, regardless of age or specialty. We urge you to include this in your plans.

When I turn to the matter of the Davidge Hall Restoration Fund, I find that there has never been submitted to our membership a written report of the genesis, progress, and current state of this project. The following is an attempt to rectify that deficiency.

Davidge Hall, constructed in 1812, five years after the founding of the School of Medicine of the University of Maryland, is the oldest building in the United States of America constructed for the purpose of teaching medicine and continuously in use for that purpose since its construction. During the past quarter of a century, the Board of Directors of the Medical Alumni Association has, on several occasions, discussed the possibility of restoration of Davidge Hall. During his tenure as president (1962-63) Dr. George H. Yeager made some informal inquiries as to the feasibility of this, and, after talking with several contractors, etc., an unofficial estimate of costs was approximately $500,000. During his term as President of the Medical Alumni Association (1967-68), Dr. John O. Sharrett initiated further inquiries. He consulted Mr. William Boucher, III, Chairman of the Greater Baltimore Committee, asking his advice as to the direction the medical alumni should take in the restoration. In the years that had intervened between the 1962-63 investigation by Dr. Yeager, the University of Maryland had spent $250,000 for structural and maintenance improvements. Therefore, it was believed that approximately $1,000,000 would be necessary for this project. With this amount of money in mind and after hearing of the number of medical alumni involved, Mr. Boucher advised that the campaign be run locally by ourselves and that we obtain the aid of an advertising concern. For further affirmation, a fund-raising agency was consulted. The Medical Alumni Association was informed that the cost for telling us how to start such a campaign would be $3,000, plus out-of-pocket expenses, and, if they

were to run the campaign, supervising our fund-raising efforts, the cost would be another 25% of the gross. Accordingly, the Board of Directors elected to follow the advice of Mr. Boucher and run the campaign ourselves with the help of an advertising concern.

In January, 1970, Dr. Wilfred H. Townshend, Jr., then president of the Medical Alumni Association, appointed Dr. John O. Sharrett, Chairman of the Davidge Hall Restoration Fund Committee. One of the brothers of Dr. John C. Dumler, at the request of Dr. Dumler, traced the deed of Davidge Hall and this was completed by late 1971. The committee's efforts were directed toward having the historical significance of Davidge Hall recognized by the City, State, and Federal Government. By May, 1970, Davidge Hall was on the list of the first twenty buildings in Baltimore to be recognized by the Council for the Commission for Historical and Architectural Representations. It was not until December 10, 1973, that Mayor Schaefer informed us that approval had been obtained from the City of Baltimore for such listing. Mr. James Kardash, brother of Dr. Theodore Kardash, and at that time a member of the State Legislature, sponsored in the State Legislature, House Bill #10 (House Joint Resolution 55) recognizing ". . . Davidge Hall, located on the Baltimore City campus of the University of Maryland School of Medicine as a State historical site . . ." This bill was approved by the State Legislature on April 15, 1970. Pursuant to our application to the Department of the Interior, Davidge Hall was placed on the National Register of Historical Places on April 24, 1974.

When we looked into the matter of architectural planning for restoration, we were informed that the customary procedure involves three stages of survey and planning. On March 24, 1970, Tatar & Kelly, Architects, made a preliminary architectural survey, valued at $2,000 which they donated. This led to a second-stage contract with the same organization for a preliminary study at a cost of $5,200. Meanwhile, Tatar & Kelly had merged with Cochran, Stephenson & Donkervoet, and accordingly, the third and final stage contract was signed with the latter firm. The cost of this third-stage architectural effort was $34,000, and it was estimated that the additional costs for paperwork necessary to obtain grants would bring this to a total of $42,000. It is hoped that approximately $17,000 will be obtained in grants to help pay the costs of these architectural studies. This study has not yet been completed, though it is anticipated that this third stage will be completed during the calendar year 1976 and actual restoration work may commence.

Mr. Wilbur Hunter, Director of the Peale Museum, recently toured the building and commented that we were not starting from scratch as Williamsburg did, but rather had already in our possession a substantial building. He believed that adequate restoration could be made and still retain usefulness of its accommodations to the benefit of the Medical School and alumni.

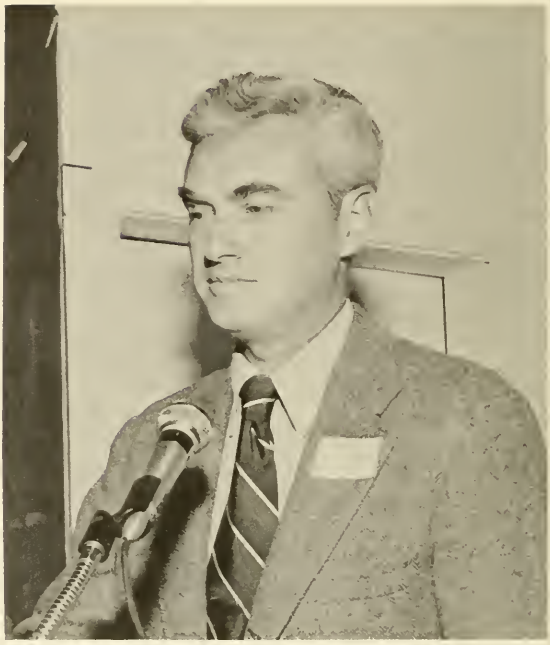
A new Davidge Hall committee was appointed by Dr. William J. R. Dunseath (1973-74), but this committee's work at present is at a standstill since it is unable to continue with a drive for funds other than those solicited from alumni until the architects have completed the third stage of the survey and an appropriate estimate as to reconstruction costs is available.

The registration of Davidge Hall as a City, State, and National historic place assures the perpetuity of the building regardless of any future changes in zoning regulations. Although it is planned that in the summer or fall of 1976, many of the activities of the Dean of the School of Medicine will be carried out in a new office in Howard Hall, the Dean and the Davidge Hall Restoration Committee have agreed that the Dean will retain one office in Davidge Hall. It was further agreed that any assignment of space for specific functions would be made by agreement of the Dean and the Medical Alumni Association. We have been assured by the Dean that the day-to-day upkeep and maintenance of Davidge Hall will be continued by the University of Maryland. Up to the present, $104,000 has been contributed by alumni. The Davidge Hall Restoration Fund Committee has accumulated data concerning the availability of further funds from foundations, trusts, etc. Although some such requests for funds have already been filed and are being pursued, most of these, as stated above, require that specific data concerning precise architectural changes to be made and accurate cost estimates be included in the application before it can be filed. As stated above, it is anticipated that these data will become available during the calendar year 1976.

With this historical resume as a baseline, I hope that future progress reports may keep our alumni fully informed as to the current status of this project in which all of us may take justifiable pride.

MARYLAND DAY MEDI
Saturd
Brunswick Hospital Cen

Dr. E.T. Lisansky, Moderator of the first session of the program, addresses the group.



Dr. G. Robert Mason spoke on the "Initial Management of the Injured Patient."

Dr. Dennis K. Wentz was the moderator of the latter part of the program.

Dr. James A. Roberts, President-Elect, Dr. Robert B. Goldstein, Past President, Dr. William H. Mosberg, Jr., President & Dr. Benjamin Stein chatting about the presentations.

MNI CONFERENCE
ober 18, 1975
tyville, New York

"Alcoholism – Medical Complications" was the topic of Dr. Frank Iber's address.

(L-R) Dr. Frank Field, NBC-TV Science Editor, Dr. John M. Dennis, Dean of University of Maryland School of Medicine, and Dr. Benjamin M. Stein, President of Brunswick Hospital Center, looking over the program.

Attendees at the scientific session.

Dr. Roger Michael discusses the "Acute Management of Musculoskeletal Injuries."

JUNIOR OYSTER ROAST

Dr. William H. Mosberg, Jr., President of the Medical Alumni Association, is assisted by 1977 Class Vice President, Patricia D. Fosarelli, in drawing door prizes.

The food and company were enjoyed by the family of Dr. Joseph D'Antonio (1946), who completed a table of ten.

An Oyster Roast for the Junior Class of the Medical School was sponsored by the Medical Alumni Association on Friday evening, November 7, 1975 at the Hunt Valley Inn.

The invitation was extended to each member of the 1977 Class and a guest. The attendance numbered 300, including 100 alumni and faculty members.

Not only were oysters and other delectable foods in abundance, but also lively conversation and good fellowship among the students, alumni and faculty.

Members of the Junior Class, dispersed as they are during the present year, appeared especially to enjoy their own class reunion.

Bob Robison (1977), Mrs. Robison, Jerry Ginsberg (1977) and his fiancee, Barbara Rosensweig, (now Mrs. Ginsberg) wait for chef-carved beef.

Dr. Bernice Sigman (1960), Ass't Professor, Pediatrics; Dr. Karl H. Weaver (1953), Professor, Pediatrics, and Mrs. Ruth Smith, wife of Dr. Keith L. Smith, Ass't Professor of Sociology, Soc. and Prev. Medicine.

MEDICAL ALUMNI ASSOCIATION REUNION SCHEDULE

Wednesday, June 2, 1976

7:00 p.m.	Alumni Reception Hunt Valley Inn Shawan Road and Rt. 1-83
8:00 p.m.	Annual Alumni Banquet Followed by dancing until 1:00 a.m.

Thursday, June 3, 1976

9:00 a.m.	Registration Davidge Hall
10:00 a.m.	Annual Alumni Business Meeting Scientific Program (details later) Davidge Hall
12:30 p.m.	Alumni Luncheon Circle One Restaurant Holiday Inn
6:00-11:00 p.m.	Alumni Cocktail Reception Davidge Hall

Friday, June 4, 1976

(Time and place to be announced)	Precommencement Exercises
	Commencement Exercises

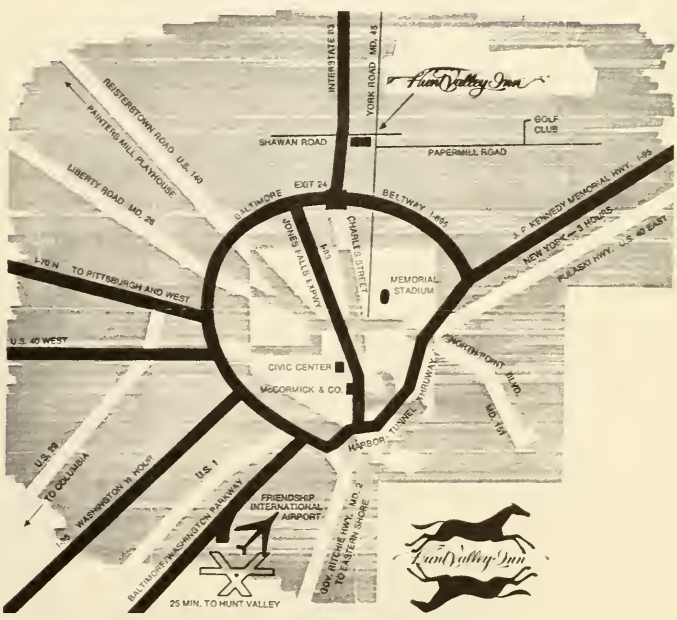
HOTEL ACCOMODATIONS

Holiday Inn-Downtown
Lombard and Howard Streets
Baltimore, MD. 21201
Phone:301/685-3500

The Baltimore Hilton
101 W. Fayette Street
Baltimore, MD 21201
Phone:301/752-1100

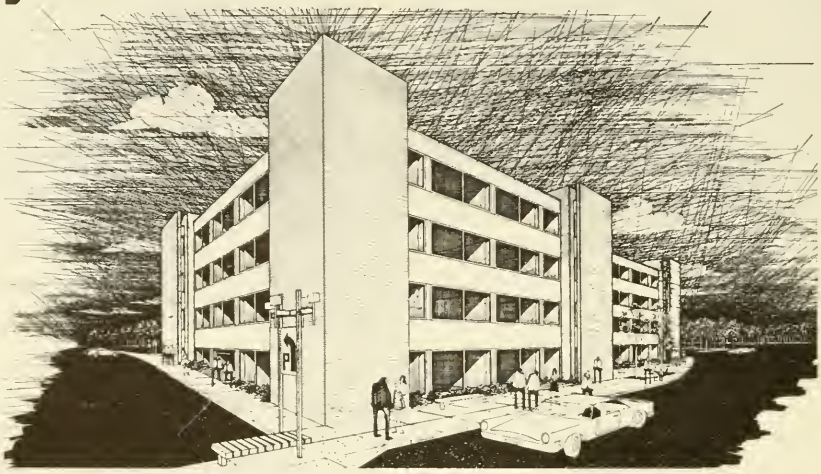
Hunt Valley Inn
Interstate 83 at Shawan Rd.
Hunt Valley Md. 21031
Phone: 301/666/7000
Reservations must be made by
May 19.

Lord Baltimore Hotel
Baltimore and Hanover Streets
Baltimore, MD 21203
Phone: 301/539-8400



Note: Courtesy bus transportation will be provided for out-of-town alumni for all activities.

Osler Medical Center. It's just what the doctor ordered.



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ALUMNI CHATTER

Nelson Hendler, '72, Baltimore, Md., has been appointed to Assistant Professor of Neurosurgery in Psychiatry and Instructor in Psychiatry at Johns Hopkins Hospital. Dr. Hendler had an article entitled, "Lithium Responsive Hyperaldorteronism in Manic Patients," published in the *Journal of Nervous and Mental Disease,* 161:49, in July, 1975. He teaches a Continuing Education Course, "Psychodrama-Theory and Technique," and directs a biofeedback laboratory for chronic pain, temporomandibular joint and headache patients as part of the "Pain Center"—Johns Hopkins Hospital.

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John A. Niziol, '72, Wayne, N.J., completed his internship and residency in Pediatrics at the Children's Hospital, University of Pittsburgh. Presently, he is engaged in pediatric practice in Clifton, New Jersey.

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Louis A. Shpritz, '70, Baltimore, Md., holds an appointment as Instructor in the Division of Urology, Department of Surgery, University of Maryland Hospital.

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Kenneth C. Ullman, '69, Silver Spring, Md., was certified by the American Board of Psychiatry and Neurology in 1975. Dr. Ullman has opened an office for the practice of General Psychiatry in Washington, D.C. and holds an appointment as Clinical Instructor in Psychiatry at the Georgetown University Medical School.

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Major Donald M. Baldwin, '69, Ft. Sill, Oklahoma, is presently Chief of Orthopedic Surgery at Reynolds Army Hospital at Ft. Sill and was recently certified by the American Board of Orthopedic Surgery.

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James O. Ballard, III, '69, Hershey, Pa., was Board Certified in Internal Medicine in June, 1972. He is currently a Fellow in Hematology and an Associate in Medicine at Pennsylvania State University Milton S. Hershey Medical Center. In the November, 1975 issue of the *Bulletin* Dr. Ballard's title was incorrectly stated.

Elliot S. Cohen, '68, Heidelberg, Germany was recently made Chief, Mental Hygiene Consultation Service at the 130th Station Hospital, U.S. Army, Heidelberg, Germany. Dr. Cohen completed his residency in Psychiatry at the Institute of Psychiatry and Human Behavior at the University of Maryland School of Medicine.

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Marvin C. Sachs, '67, Panorama City, California, was certified by the American Board of Pediatrics in October, 1974 and became a Fellow of the American Academy of Pediatrics in June, 1975. Dr. Sachs is a Clinical Instructor in the Department of Pediatrics at the UCLA School of Medicine.

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James G. Zimmerly, M.D., J.D., M.P.H., '66, Balto. Md., has been reappointed to a second term as Vice-Chairman of the American Bar Association's Committee on Law and Medicine. In addition, Dr.

Zimmerly has been appointed Chairman of the ABA's new sub-committee on Medical Malpractice Development. Dr. Zimmerly is solicitous of comments on any aspect of the medical malpractice problem from Maryland physicians. Comments may be addressed to him at Physicians Memorial Hospital, La Plata, Md.

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George E. Engelke, '65, Baltimore, Md., has been appointed chairman of the department of emergency services at St. Agnes Hospital effective October 1, 1975 according to Sister Alberta, D.C., hospital administrator.

Dr. Engelke takes responisbility for directing the medical care delivered in the St. Agnes Hospital emergency room.

Each year, St. Agnes Hospital treats more than 60,000 emergency patients from the Southwest Baltimore Metropolitan area.

Dr. Engelke is not new to the St. Agnes Hospital community. He has been an active member of gynecology and emergency services attending staff for the past five years. Dr. Engelke conducted both his internship and residency training in obstetrics and gynecology at St. Agnes prior to joining the attending staff.

A native of Annapolis, Maryland, Dr. Engelke attended the Georgetown University in Washington, D.C. on a General Motors scholarship, then entered the University of Maryland School of Medicine. Upon graduation, he served two years in the United States Navy having been discharged with the rank of Lieutenant Commander.

Dr. Engelke is a member of the American College of Obstetrics and Gynecology, the American College of Emergency Physicians, and the Medical and Chirurgical Faculty of Maryland.

Virginia Truitt Sheer, '56, Holland, Pa., was certified by the American Board of Psychiatry in 1967. In 1975, she received the Montgomery County, Pennsylvania Medical Society's Annual Clinical Research Award and was elected a Fellow of the American Psychiatric Association.

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Arthur C. Knight, '53 Deer Lodge Montana, has been appointed Director of the State of Montana's Department of Health and Environmental Sciences. Dr. Knight will be vacating the posts of Superintendent of Galen State Hospital and Coordinator of Hospital Facilities Division of the Department of Institutions.

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Joseph B. Workman, '46, Durham, N.C., Professor of Nuclear Medicine at Duke University Medical Center, received the Degree of Fellowship of the American College of Nuclear Medicine at its annual meeting in Orlando, Florida.

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John M. Dennis, '45, Baltimore, Md., Dean of the University of Maryland School of Medicine was named Vice Chancellor for Health Affairs by the Board of Regents of the University in November, 1975.

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A Note of Thanks . . .

The *Bulletin* staff wishes to thank Dr. Merrill J. Snyder of the Division of Infectious Diseases for his kind interest and assistance in the preparation of the November, 1975 issue of the *Bulletin* which featured the Annual Report of the Department of Medicine of University of Maryland Hospital.

FACULTY NEWS

Appointments, Promotions, and Resignations

Elaine S. Choi, M.D., Assistant Professor — MEDICINE (appointment effective 7-1-75)

Kathleen Cole, M.S., Clinical Assistant Professor — PSYCHIATRY (appointment effective 9-1-75)

Charles R. Goshen, M.D., Clinical Assistant Professor — PSYCHIATRY (promotion effective 7-1-75)

Alpaslan M. Karahasanoglu, Ph.D., Assistant Professor — PEDIATRICS (joint appointment effective 7-1-75)

Ramesh K. Khurana, M.B., B.S., Assistant Professor — NEUROLOGY (promotion effective 7-1-75)

Denis J. Madden, Ph.D., Clinical Assistant Professor — PSYCHIATRY (promotion effective 7-1-75)

Zulema Reggiardo, Ph.D., Assistant Professor — PATHOLOGY (promotion effective 7-1-75)

Robert M. Russell, M.D., Assistant Professor — MEDICINE (appointment effective 9-1-75)

George D. Yannakakis, M.D., Associate Professor — MEDICINE (appointment effective 7-1-75)

Elias George Elias, M.D., Associate Professor — SURGERY (appointment effective 10-12-75)

Warren M. Ross, M.D., Instructor — FAMILY MEDICINE (appointment effective 9-28-75)

Samuel Moore, Jr., M.S., Clinical Associate — PATHOLOGY (appointment effective 10-15-75)

Allen James Ottens, Ph.D., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 9-1-75)

Graham Fallon, M.D., Assistant Professor — SURGERY (appointment effective 9-15-75)

Thira Assavathanta, M.D., Assistant Professor — OBSTETRICS/GYNECOLOGY (appointment effective 10-1-75)

Charles C. Edwards, M.D., Assistant Professor — SURGERY (appointment effective 9-15-75)

Peter Coleman, M.D., Assistant Professor — PSYCHIATRY (promotion effective 7-1-75)

J. Ramsay Farah, M.D., Instructor — PEDIATRICS (appointment effective 11-1-75)

Mary Hall-Craggs, M.B., B.S., Assistant Professor — PATHOLOGY (appointment effective 10-1-75)

William L. Holder, M.D., Assistant Professor — PSYCHIATRY (promotion effective 7-1-75)

Joseph T. Joseph, Ph.D., Research Associate — BIOPHYSICS (appointment effective 9-1-75)

Douglas C. Murphy, M.A., Instructor — PSYCHIATRY (promotion effective 10-1-75)

Gary D. Plotnick, M.D., Assistant Dean — OFFICE OF STUDENT AFFAIRS (appointment effective 9-1-75)

Salvatore Raiti, M.R.C.P., Associate Professor — OBSTETRICS/GYNECOLOGY (appointment effective 9-1-75)

Stephen W. Saunders, M.D., Instructor — PSYCHIATRY (appointment effective 7-1-75)

Janice P. Ware, M.Ed., Instructor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 9-1-75)

P. Oliver Maher, FFARCSI, Assistant Professor — ANESTHESIOLOGY (change of status effective 10-1-75)

Katherine V. Kemp, M.D., Clinical Assistant Professor — PSYCHIATRY (appointment effective 10-1-75)

Dwo Lynm, Ph.D., Assistant Professor — MEDICAL TECHNOLOGY (PATHOLOGY) (appointment effective 9-24-75)

Evelyn McElroy, Ph.D., Assistant Professor — PSYCHIATRY (promotion effective 7-1-75)

A. Harry Oleynick, M.D., Clinical Assistant Professor — PSYCHIATRY (promotion effective 9-1-75)

Norma H. Vincent, Ph.D., Research Associate — PATHOLOGY (appointment effective 9-1-75)

Benjamin David White, M.D., Associate Professor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 1-1-75)

Robert J. Wilensky, M.D., Instructor — SURGERY (appointment effective 10-21-75)

Edward F. Cotter, M.D., Associate Professor Emeritus — MEDICINE (change of status effective 7-1-75)

Margaret W. Bridwell, M.D., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-75)

Gerald Felsenthal, M.D., Assistant Professor — REHABILITATION MEDICINE (promotion effective 1-1-76)

Frances J. Fitch, M.S., Instructor — PSYCHIATRY (appointment effective 11-1-75)

Yrjo U. Collan, M.D., Research Associate — PATHOLOGY, resigned 10-7-75.

James Q. Whitaker, M.D., Clinical Assistant Professor — PATHOLOGY, resigned.

Elaine A. Richman, B.A., Associate — MEDICINE, resigned 9-30-75.

Alexander Tsafriri, Ph.D., Associate — PHYSIOLOGY, resigned, '75.

George W. Krause, M.S., Instructor — PATHOLOGY, resigned.

Willie Q. Cartwright, Assistant Professor — MEDICAL TECHNOLOGY, resigned.

Ruth S. Ashman, M.D., Instructor — PEDIATRICS, resigned 6-30-75.

Mithat Coruh, M.D., Visiting Professor — PEDIATRICS, resigned 7-30-75.

Robert Dawson, M.D., Clinical Assistant Professor — PEDIATRICS, resigned 6-30-75.

Earlie Francis, M.D., Instructor — PEDIATRICS, resigned.

Richard L. London, M.D., Clinical Assistant Professor — PEDIATRICS, resigned 11-3-73.

Polly Roberts, M.D., Clinical Instructor — PEDIATRICS, resigned 6-30-74.

Lois M. Roeder, D.Sc., Assistant Professor — PEDIATRICS, resigned 9-11-74.

Robert E. Yim, M.D., Clinical Assistant Professor — PEDIATRICS, resigned.

Sherian Seubott, B.S., Clinical Instructor — PHYSICAL THERAPY, resigned 6-75.

Milton R. Horwitz, M.D., Assistant Professor — SURGERY, resigned, '75.

Jorge R. Ordonez, M.D., Instructor — SURGERY, resigned, '75.

Joseph Orlando, M.D., Assistant Professor — SURGERY, resigned, '75.

Juan M. Pardo, M.D., Instructor — SURGERY, resigned, '75.

Chawalit Suddhimondala, M.D., Instructor — SURGERY, resigned, '75.

Norman Dubin, Ph.D., Assistant Professor — OBSTETRICS/GYNECOLOGY, resigned 10-20-75.

Pavitros Tuladhar, M.D., Instructor — ANESTHESIOLOGY, resigned 9-27-75.

John Powell Williams, M.D., Associate Professor — RADIOLOGY, resigned 2-29-76.

Audrey L. Kocher, M.S., Research Associate — SOCIAL & PREVENTIVE MEDICINE, resigned 12-1-75.

Bernard M. McGibbon, M.D., Associate — SURGERY (appointment effective 7-1-75)

Charles J. E. Arnold, M.D., Clinical Instructor — RADIOLOGY (appointment effective 9-1-75)

Gwynne Horwits, M.D., Instructor — ANESTHESIOLOGY (appointment effective 9-1-75)

Beatriz P. Arrieta, B.A., R.T., Associate — RADIOLOGY (appointment effective 8-1-75)

Zoland Z. Zile, III, R.T., M.S., Instructor — RADIOLOGY (appointment effective 8-11-75)

Kathryn A. Brick, M.S., Instructor — PHYSICAL THERAPY (appointment effective 8-11-75)

Gad Alon, M.S., Instructor — PHYSICAL THERAPY (appointment effective 9-1-75)

William W. Magruder, M.D., Clinical Assistant Professor — PSYCHIATRY (reinstated)

Hans J. Koetter, M.D., Assistant Professor — FAMILY MEDICINE (reinstated)

Elsie M. Reinhardt, R.N., B.S., Associate — NEUROLOGY, resigned 8-1-75.

Donald S. Geduldig, Assistant Professor — BIOPHYSICS, resigned 8-31-75.

Samuel L. Fox, Professor — OPHTHALMOLOGY, deceased 8-2-75.

Carroll W. Hughes, Instructor — PEDIATRICS, resigned 6-30-75.

Maureen Henderson, Professor & Chairman — SOCIAL & PREVENTIVE MEDICINE, resigned 12-15-75.

Patrick N. Connaughton, Assistant Professor — RADIOLOGY, resigned 8-31-75.

Thomas Morgan, Professor — SURGERY, resigned 7-31-75.

Leonard A. Stone, Instructor — PHYSICAL THERAPY, resigned 8-24-75.

Chawalit Suddhimondala, M.D., Instructor — SURGERY (Reinstated)

Jorge R. Ordonez, M.D., Instructor — SURGERY (Reinstated)

Joseph C. Orlando, M.D., Assistant Professor — SURGERY (Reinstated)

Juan M. Pardo, M.D., Instructor — SURGERY (Reinstated)

George J. Mehler, M.D., Associate — SURGERY (appointment effective 10-27-75)

Susan M. Cohen, M.D., Instructor — ANESTHESIOLOGY (appointment effective 1-1-76)

Ruben F. Ballesteros, M.D., Associate — SURGERY (appointment effective 10-15-75)

Lawrence Blumberg, M.D., Instructor — SURGERY (appointment effective 11-1-75)

Curtis L. Decker, J.D., Clinical Instructor — PSYCHIATRY (appointment effective 1-1-76)

Alice B. Heisler-Hayes, M.D., Clinical Assistant Professor — PEDIATRICS (promotion effective 9-1-75)

Lenore W. Howard, M.A., Assistant Professor — PEDIATRICS (promotion effective 9-1-75)

Irina Steiman, M.Sc., Research Associate — MICROBIOLOGY (appointment effective 11-1-75)

Lajos Tima, M.D., Visiting Assistant Professor — PHYSIOLOGY (appointment effective 10-27-75)

Paul J. Reier, Ph.D., Assistant Professor — ANATOMY (appointment effective 12-1-75)

ALUMNI NEWS REPORT

TO THE BULLETIN:

I would like to report the following: _____

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SUGGESTIONS FOR ITEMS

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May, 1976

BULLETIN

university of maryland school of medicine

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Compulsory National Health Insurance: What You Will Get and What It Will Cost

William H. Mosberg, Jr., M.D.
and W. J. Nelson, M.D.

"We now must try a system that does work satisfactory (sic) *in all the democratic nations of the Western world. Just as Social Security was opposed as socialism, those who oppose this try to scare the American people, but we have learned that without a national health insurance system there will not be health security."* S. Schats[64]

"The American people must realize that it is physically impossible to get something for nothing, and sooner or later someone must pay for all give-aways. Lacking such understanding, it is inevitable that our tax burdens will increase, while we are sure to get less and less services and goods in return."
R. W. Clairborne[17]

"We can make no pronouncements, espouse no causes, critique no system, and take no position if it opposes the ultimate government control of medicine and is signed with the letters M.D."
G. D. Le Maitre[47]

The preceding quotations set forth dramatically the opposing views on government medicine and also help explain why the medical profession—the most logical and most informed source of guidance and counsel—has not been able to shed any significant portion of the much needed enlightenment on the subject. When we were called upon to prepare this editorial, we assumed it was because of our having spent significant periods of time abroad and our having numerous personal experiences in countries in which medicine is nationalized. Because we are told that "more than most men, doctors react against unsupported opinions and unproved generalities",[14] we elected not to set forth our personal observations or even the personal opinions of neurosurgeons with whom we are acquainted in various parts of the world. Furthermore, we recognize that any adverse effect that nationalized medicine may have upon the medical profession will play no role in ultimate decisions regarding the implementation of such national health schemes. Therefore, we have elected to approach this problem, not as neurosurgeons or even as doctors of medicine, but rather as citizens and taxpayers. When one is deciding whether or not to make a purchase, one logically asks himself:

1) What will I get for my money?
2) How much will it cost?
3) Can I afford it?

Quoting from available literature on the subject, we shall attempt an answer to these three questions.

What Will I Get For My Money?

"Our humble policy is to create a National Health Service to ensure that everybody, irrespective of means, age, sex, or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available."
W. Churchill[15]

"The United States has failed to provide adequate health services to the vast majority of its citizens . . . Without a drastic alteration of the present delivery system, the adoption of a (national health financing) system or any other massive infusion of new federal monies will simply compound the failure of the present system." S. A. Law[46]

Perhaps the most direct and objective answer to this question appears in a paper from the Rand Corporation authored by Newhouse et al[54] from which the following is quoted:

"The data indicate that under full coverage or 25% maximum co-insurance, demand for hospital service would rise modestly. However, either program would greatly increase demand for ambulatory services and would stress the delivery system, with resulting increased price of physicians' services, queuing, or less physician time per patient—all without increasing total delivery of ambulatory services. Ambulatory services would be redistributed from the affluent to the poor. A catastrophic health insurance program would not stress the ambulatory system.

"Reorganization of the delivery of ambulatory services into prepaid groups will probably not increase productivity, nor will emphasis on preventive medicine reduce overall demand for health services. National insurance providing more health services would not appreciably affect objective indexes of health (life expectancy), but

should improve subjective but relatively unquantifiable elements such as quality of life." The conclusions of Newhouse, et al were challenged in several letters to the editor in the September 19, 1974, issue of the New England Journal of Medicine. The interested reader is referred to that issue of the journal not only for the questions raised in letters to the editor but also for the answers to these questions provided by Newhouse et al.[54]

Since one of these letters to the editor[31] dealt with the perenially-recurring canard of infant mortality, we shall devote some specific attention to that point. In an editorial in 1971, Balfe[4] made the point that "The infant death rate is not the best, or even a good indicator of the health status of a nation or the efficacy of a nation's health delivery system. *Infant mortality is, for the most part, a social rather than a medical problem.* Such factors as poverty, malnutrition, poor housing, low education levels, and racial or ethnic differences are surely much more highly correlated with infant mortality than are such factors as the number of physicians or hospitals." To demonstrate the fallacy of such reasoning, Balfe[4] went on to state that one can "prove" by using World Health Statistics Report (1970) the following:

Sweden has the best health system because it has the lowest infant death rate.

Netherlands has the best health system because it has the lowest death rate due to both tuberculosis and pneumonia.

The United States has the best health system because it has the lowest death rate due to bronchitis.

France has the best health system because it has the lowest death rate due to ulcer of the stomach.

DuVal,[23] writing on this subject, has stated: "A recent report from the California Medical Association, for example, notes that 'poor nutrition, failure to seek or follow medical advice . . . teenage and illegitimate births' are highly conducive to such things as a significantly greater infant mortality here than in other developed nations. The report also notes that 'in urban poverty-tract areas, there are large numbers of immigrants from the rural South and from Appalachia who are not aware of the benefits of good health care. Our professional associations also note that, even beyond such indices as infant mortality and life expectancy, there are other forces at work in our society which compromise the health of our people. Prime among these is our own human behavior. We eat, drink, and smoke too much, and drive recklessly on the highways—all in that great tradition of American optimism which says, 'It can't happen to me.' In other words, if there is a crisis—and medical professionals are not prepared to admit that there is—it is not a crisis that stems from defects in America's medical care delivery system."

In challenging the conclusions of Newhouse et al,[54] Ford[31] quoted a study by Kessner et al,[43] and indicated that infant mortality in New York was reduced by adequate medical care during pregnancy and delivery. Newhouse et al[54] replied that Kessner's[43] study did not establish a casual link between medical care and infant mortality because the mothers who sought medical care may well have differed, through self selection, from those who did not in such important matters as income and quality of diet. Newhouse et al[54] made the point that infant mortality rates during the past decade have dropped dramatically in the United States but also in all developed countries, including those whose financing mechanisms for health care had not been changed.[69] Balfe[4] stated that the infant death rate in the United States in 1940 was 47 per 1,000 live births, has steadily declined, and in 1969 was 20.7 per 1,000 live births. To place this matter even further into its proper perspective, Newhouse et al[54] stated:. . . Even if the mortality rate would be lowered from its 1972 level of 18.5 per 1,000 births to as low as 10 per 1,000 (lower than for any developed country), the effect on life expectancy would be only 0.6 years or less than one percent." There are two other bits of information which help place the infant mortality canard in its proper persepctive. Actually Sweden had the lowest infant mortality prior to the institution of compulsory health insurance in 1955.[70] The 1971 volume of World Health Statistics Annual published by *WHO* in 1974[78] lists not Sweden but Egypt as having the lowest perinatal mortality. Egypt is lower than Sweden both in early neonatal mortality and late fetal mortality.

The health insurance plans in continental Europe owe their origin to industrialization which occurred in the second half of the Nineteenth Century and the compulsory social insurance plans that resulted therefrom. With the new emphasis on work away from home and the increased risks of illness and injury, the family was no longer dependable as a means of economic security. At the same time, wages were too low to permit sufficient savings or to pay for commercial insurance. Initially the insured were only a small minority of patients and for the most part the traditionally poor whom the physicians and the hospitals had to treat free of charge in any case. After World War I, the funds were shifted from private organizations to public institutions. In recent decades, the number of insured patients has risen sharply, as

have medical care costs. Coverage, medical benefits, and administrative organization vary from one country to another. A summary of the health insurance systems of Belgium, Federal Republic of Germany, France, Italy, Luxembourg, and the Netherlands have been described by Langendonck.[45]

Volumes have been written about the national health service in the United Kingdom. Its 27 years of operational experience since its inception in 1948 have been fraught with many problems. Initially it was planned that all services—eye glasses, medicines, prostheses, false teeth, etc.—would be provided free of charge. The financial impracticality of this rapidly became evident and many of these services were curtailed. Those of us who lived in Great Britain in the early years of the national health service concluded as did Fox:[33] "I did not find one physician who liked the National Health Service Plan as then in effect. However, nearly all felt that it was well to have a Health Service Plan and that the broadest scope of care is necessary. Physicians feel that before the present plan was adopted they should have proposed and set up a definite plan which should have been acceptable and far less expensive." As long ago as 1960, the president of the British Medical Association in his inaugural speech[12] said that the time had come to lift medicine in Britain out of the realm of party politics which had bedeviled it from the start of the nationalized program eleven years ago. ". . .There is no doubt that the original idea of partnership has been steadily and slowly — almost insidiously — displaced by what has been aptly called the 'employer-employee relationship,' the profession being the employee, . . ." The same article went on to state that the physician must take on so many patients to make a decent living that he is unable to give them the individual attention they should have; that a typical general practitioner in Britain treats two thousand patients; and for each patient, he is allowed to charge the government $2.52 per year. Twice in the preceding four years the British Medical Association had threatened a mass walkout from the health service to get pay raises for physicians. The same article went on to state: "A long wait for elective surgery is another patient complaint. One big London hospital's office file lists patients who have been waiting for as long as three years. It is not considered unusual to wait four or five months for a tonsillectomy . . . Britain is suffering from a serious shortage of hospital bed space. The Royal Commission has estimated that 45% of all hospitals in the United Kingdom were built before 1891 and 21% before 1861." Even earlier in 1957, the British Medical Journal came to the same conclusion: "We have had amply demonstrated to us that medicine and politics do not mix."[66] This, it added, was something that the British profession "has been rather reluctant to admit without trial. Maybe the trial was necessary to bring home this painful truth."[66] In Britain in 1946, the Spens Committee recommended certain pay rates for general practitioners. Then in 1948, the year the NHS went into effect, the Committee made similar recommendations on what specialists should be paid. The Committee made its recommendations in terms of the 1939 value of money and said doctors' pay should be periodically readjusted to meet future changes in the cost of living and in the financial status of other professions. At the time the doctors were given to understand that the government accepted these recommendations. During the following nine years, however, various British Ministers of Health tried to wriggle out of the Spens agreement by sometimes saying that the Spens report made them responsible for adjusting doctors' pay only during the first year the NHS was in operation. At that time, it was stated that a typical physician earned a before-taxes income of well under $7,000 and a spokesman for the British Medical Association said the typical consultant earned $9,800 before taxes.[66] Even those who wrote evangelistically in favor of Britain's National Health Service recognized the shortcomings of the system. "For emergencies, the National Health Service is missile-fast. But for elective procedures, it can be slow as the mills of God. A well-trussed hernia can wait years before your surgeon gets around to it. You may have to wait a year for a routine tonsillectomy. NHS speed depends on the bed situation. . ."[19] Having waited for months or years, the patient's problems were not at an end: "There is virtually no choice of specialist for the NHS patient, though. Specialists work as part of the hospital service. Your family doctor can refer you to a given man at your city's hospital; but that doesn't insure that your gallbladder won't be lifted by someone else. In American parlance, all patients in NHS hospitals are service patients."[19]

British physicians complained of government control of their medical practice. "Government medicine is mass medicine, economy medicine. The individual is lost sight of and becomes a mere cipher, a statistic. Always the government exercises stringent control to cut costs and to do everything as cheaply as possible. Nowhere does this bureaucratic pattern strike deeper into the heart of good medical practice than in the field of drug prescribing. The bureaucrat sees a large number of drugs for one condition as being untidy, uneconomic; so he insists that only one or two be

prescribed. These, of course, must be the cheapest . . . In all of this, of course, the patient is the forgotten man. When his doctor is hedged around and prevented from prescribing what he judges to be the best remedy for that particular ailment in that particular patient, the sick person is getting second-rate medical care by any standard. This is what inevitably must happen when medical decisions are taken out of the hands of trained professionals and given to politicians and bureaucrats unable to comprehend that people are not machines and do not act uniformly."[21]

The situation in Britain has worsened and, as a result, in April, 1974 a massive restructuring was instituted.[5] This restructuring, aimed at introducing greater managerial efficiency and a better balance between hospital-based specialists and community practitioners, has been less than successful. The Labor Government, apparently determined to eliminate every vestige of private practice, refused the consultants a raise in pay and offered the consultants new contracts under which they would lose some of their state salary if they spent any time in private practice. The consultants retaliated by limiting their work to 38 hours per week, which was their contractual requirement. Previously they had been putting in an average of 20 additional hours per week without pay. The standardization of pay for consultants has led to the young physician choosing a specialty which requires fewer years of training and which offers a career which is less arduous and taxing physically and emotionally. Physicians and surgeons who were formerly proponents of the National Health Service in Great Britain now complain of the inflexibility in structure of the health service, the rigidity of the chain of command, the deterioration of service and morale, the increasing influence of politicians, and the progressive cutback in funds.

No one would question the ability and dedication of the British physician, but he is forced to practice in hospitals which in many instances are Victorian monstrosities.[20] With the declining availability of private practice for the British patient, a particularly bitter pill for the ever proud Briton to swallow must be the construction of the new Wellington Hospital. We are told that few Britons can afford the $120 to $150 per day hospital costs and the hospital is populated largely by foreigners.[20] As an index of redistribution of wealth in the world, we are told that five Arabic newspapers are on sale in the lobby of the hospital and that color television, available in each room, consists of two English channels and one Arabic channel.[20]

Because it is regarded as another epitome of nationalized medicine, the Swedish medical system also deserves consideration. Prior to 1955, health insurance in Sweden was voluntary. In that year the Swedish National Health Insurance created a national compulsory tax-financed health insurance.[70] At the time, Doctor Dag Knutson, president of the Swedish Medical Association, referring to British and Belgian precedents as "frightening," said he hoped that Sweden could at least avoid the hysteria that in other countries seemed to impel a rush for eye glasses and false teeth. The Swedes had reason for some optimism in that even before the advent of their compulsory health insurance plan in 1955, Sweden's national health standards had long been high with the average life span there being 69 years and the infant mortality rate at that time—*prior to the institution of the compulsory health plan*—the lowest in the world.[70]

In 1963, the national compulsory tax-financed health insurance was enlarged into the National Social Insurance Act.[2] This act provided for total hospital care available equally to every citizen at no cost to the individual. Ambulatory care was provided in which the patient partially reimbursed the doctor. In 1970 the "Seven Crown Reform" set the fee to the patient for office services at seven crowns, roughly $1.40. This has since risen to twelve crowns, or approximately $2.40. Additional cost of an office visit and necessary laboratory studies, X-ray studies, etc., are subsidized by various governmental agencies. The "Seven Crown Reform" had many other effects. Government-employed doctors could no longer undertake any private practice. Any doctor in private practice could not admit patients to government-owned hospitals. This has virtually eliminated new doctors entering private practice since almost all hospitals in Sweden are government-owned. Although Sweden's bed-to-population ratio is the highest in the world, in practice there are long waiting lists of patients to be admitted to hospitals. A patient may have to wait a year for elective surgery.[2] This is because many wards are not open to patients due to staff shortages with 6.4% of positions for physicians and 5.8% of nursing positions having gone unfilled in 1971. Also open elective beds are often in short supply because many are filled by relatively well patients who would be treated on an ambulatory basis in the United States. "The patient never has his choice of doctor, but is assigned to the doctor in his ward who is often a specialist. The hospital doctors are full-time salaried government employees; many in the regional hospitals also hold university teaching

appointments . . . one of the most cutting criticisms of Swedish medical care is the charge that a Swedish patient 'has many doctors but no doctor,' since a different physician will probably treat him for each hospitalization and each outpatient visit to the hospital. The patient is often shunted between different specialty wards and clinics for brief consultations with different specialists. The 'personal physician' is rapidly becoming extinct in Sweden . . ."[60] To obtain an outpatient appointment with a specialist for evaluation may require two to four months.[60] The Swedish philosophy of reducing all citizens to social and economic equality has had a direct effect on the medical community. The doctor has become a salaried employee with fixed job description, fixed hours, and vacations. Salaries are equalized among the specialists and raises are given automatically, not based on productivity. An interesting facet is that an intern at Karolinska Hospital in Stockholm works only 55 hours per week and receives 11 weeks of paid vacation per year.[61]

Italy, with its more than 40 different governments since 1944, has been labeled "the sick man of Europe." It has been said that Italian medicine is no healthier than the body politic.[37] The Italian's lire is under attack from inflation topping 12% annually. In order to get a new piece of imported medical equipment through customs, it is said that the Italian doctor must often make use of an envelope containing a bribe.[37] If there are a pair of medical vacancies to be filled at a hospital, they are likely to be filled the "Italian way." This was described by author Luigi Barzini recently in his book, "The Italians": "The first ten candidates in order of merit are passed over in favor of number twelve, whose uncle is a Monsignore, and number eighteen, who has eight children."[37] The Italian has a tendency to see his physician often on the slightest pretext with the logic: "I am paying for it; I should get something for my *mutua*." The doctor reciprocates by almost always prescribing something and sometimes without need. "It's like the lollipop you give a kid after his tonsils are checked . . . Italy's drugs are among the highest priced in Europe, and the pharmaceutical industry is generally unregulated by the government. But who cares? The *mutua* pays."[37] In Southern Italy, the state of medical care is appaling with rickets, worms, tuberculosis, malaria, and a high infant mortality rate in 1971 of 28.3 per 100,000. Many doctors won't practice in the south of Italy and there are four times as many doctors per 100,000 patients in Rome, as in Nuoro, Calabria, and L'Aquila combined.[37]

Space does not permit a discussion of the national health scheme in other countries. The interested reader is referred to the bibliography for further information concerning such services in Canada,[35] People's Republic of China,[22,68] Denmark,[11,34] France,[8,16] Germany,[56] Japan,[44] Mexico,[50,51] Russia,[21,36,49,52,55,65,75] and Switzerland.[6]

The health care problems of the world fall into two broad categories: those of the developed or industrialized nations and those of the so-called developing nations. Evangelists of national compulsory health insurance maintain that even developing nations have a better health care system than does the United States. The bald fact is that "over one-half of the people of the world, over one billion human beings, may not see a doctor from the time they are born until they die."[18] Certainly anyone who has spent any time in developing countries has been impressed by the significant number of patient who never reach a hospital for care, the equally significant number of patients who arrive at the hospital so late in their disease that either marked permanent disability or death is inevitable, the frequency of death from actual starvation (which is virtually unknown in the U.S.A.), and the overcrowded conditions in hospitals which, for the most part, are antiquated. How many Americans have ever seen two patients in a single hospital bed or patients sleeping on the floor when hospital beds are no longer available? Even a brief conversation with one of our neurosurgical colleagues from a developing country will disclose that his salary for his position at the government hospitals may be a mere pittance and that, in order to support himself and his family, he must see the few private patients available in his office on off-duty hours. Carl Taylor[71] has reported that: "In one health center in India we found that a doctor was seeing seven hundred patients in a morning and had been commended by the state officials for his work output. Detailed work studies[62] of more typical health centers showed an average of about one minute per patient." Commenting on the inadequate infrastructure in the Indian medical system, Taylor[71] stated that the medical organization resembled an hour-glass rather than a pyramid.

In a recent study of comparative health systems, Anderson[1] concludes by stating: "The United States in the foreseeable future will not, of course, approximate the equity of the English and Swedish systems . . . Nevertheless the U.S. will probably achieve a reasonable minimum of service for those of low income although more of a gap will remain in care provided and amenities than is true in Britain and Sweden."

What Will It Cost?

". . . increasing the availability of health services will not improve the general health of the population, as 'use is a function of availability, not of need.'" M. K. DuVal[42]

The difficulty in answering this question was stated well by Illuminati,[41] as follows: "When one attempts to assess the cost of health, one is confronted with factors that cannot be precisely quantified. Not only is it difficult to quantify medical and pharmaceutical benefits provided outside the hospital system, but, and above all as we have emphasized, very many psychological factors necessarily elude any economic estimation. Moreover account should be taken of two other fundamental factors that characterize relations between doctor and patient: (A) the relations of confidence between the two parties ensured by freedom of choice on both sides; and (B) freedom to prescribe medicaments produced in conditions of free commercial competition."

Speaking of the situation in Italy, Gonzalez[37] states: "As in the United States, both workers and employers in Italy contribute to the cost of social security. But in Italy, the worker's participation in the *mutua* is sometimes as much as thirteen percent of his base pay. The cost is even higher when one realizes that the company's participation in the *mutua* sometimes amounts to 50% of its payroll. A worker earning $100 per week, for example, may cost his company $150 by the time the cost of social security taxes, paid by the employer, is included. . . . Despite all of the funds that are poured into the medical system from workers, employers, and the government, it is awash in debt. Italy's total national income is some 33 trillion lire (about 48 billion, 180 million dollars), but the health system is currently about two trillion lire (about 2 billion, 920 million dollars) in the red. Money is so tight that some insurance companies hold up payments to doctors and hospitals on the slightest pretext just to stem the tide of red ink."

In Sweden for 1970 to 1971, social welfare expenses, according to Andrews,[2] including health care, were 28% of the total government expenses compared to 17% for education and 13% for military expenses. Health costs in 1969 were 1.4 billion dollars, representing 5.5% of Sweden's gross national product. These costs are increasing at a rate of about 7% per year. In 1971, the Swedish county councils spent 78% of their total budget or two billion dollars (about $250 per person) on medical care. This represented an eightfold increase compared to expenses in 1960. Andrews[2] goes on to state: "The system for health and social welfare is tax-financed and because health and social benefits are so comprehensive, total tax rates are high. For example, a married man earning $4,000 per year pays 41% of his salary for total taxes, while a man earning $10,000 per year pays 60%." Between 1952 and 1966, ambulatory visits to doctors in Sweden increased from 7.4 to 18.7 million visits annually, an increase of 250%.

In its first year, the National Health Service in Great Britain cost a bit more than one billion dollars. Ten years later, in 1958, it cost more than two billion dollars.[9] "Or to put it in terms of taxes: If the British didn't have state medicine, their income taxes could be cut to the pre-war 20½ percent. Instead, they now (i.e., 1958) pay 42½ percent. That's the difference the NHS makes, according to British Government sources." In October, 1974, David Loshak,[48] Health Services Correspondent for the Daily Telegraph, London, reported that: "The founders of the Health Service estimated its cost in 1974 would be four hundred million dollars; in fact, it is nearly twenty times that. . . . Special 'non-essential' services, such as cosmetic dentistry, operations for 'minor' complaints like varicose veins, or provision of oxygen for household asthmatics, have had to be curtailed. Even essential services have at times had to be trimmed. Some emergency wards have been closed; some cancer patients have gone potentially fatal days without radiotherapy, because of staff shortages. . . . Dozens of Britain's 2,300 hospitals are more than 100 years old—moribund and beyond modernization. The latest in a long line of despairing official reports says many hospitals are 'quite unsuitable' for patient care. One five-floor hospital, for example, has no elevator. Antiquated design means that instead of being among the most hygienic places in the Kingdom, British hospitals are among the dirtiest. In 1970, 27% of all known food poisoning took place in hospitals because of poor equipment and layout. . . . Post-operative wounds became infected in one operation out of every seven. Only 40 new hospitals have been built in Britain since the second world war. These facts about the hospitals are an index of the problems that beset the Health Service. It is the story of Utopian visions falling victim to reality. The BMA believes—in contrast with its stance a generation ago, when it opposed State intervention—that only massive Government investment can save the Health Service, and it has estimated that the minimum immediate dose to revive the patient should be 1.15 billion dollars. . . . Britains have come to realize, after a generation's experience, that when the State is a universal provider, cost-benefit perspectives go out the window. The average patient has no idea what the cost of his treatment is." So far as the effect of all of

this on the medical profession is concerned, Loshak[48] goes on to say: "It is also realized that the Health Service has falsely economized in consistently exploiting the professional dedication of its physicians, nurses, and others by keeping them chronically underpaid. Until now, it has been possible to do this because it has always been the hallmark of men and women in these professions that they were there for the work they wanted to do rather than the cash to put in their pockets. . . . According to the latest figures no newly trained British doctors are going into general practice. . . .The BMA reports that nearly ten times as many young doctors are preparing to emigrate as last year, and the rate of national loss is now around 300 trained doctors a year."

Arthur Seldon, a British economist, was reported[13] as stating that the National Health Services' performance "is increasingly deplorable for long-suffering chronically-ill Britons . . . yet it continues to be judged by its noble objective of medical care without cost or question but with rarely-discussed rationing by queuing, waiting, overcrowding, insensitivity, inefficiency, and simple non-availability." Chamberlain[13] goes on to state that: "Even as Seldon was speaking, an official report from London offered a 'first documented admission' that the National Health Service was 'grinding to a halt' because of lack of financial support from both Labor and Conservative Parties." A UPI press release in October, 1974[74] echoes the same refrain. "Last year Britain devoted 5½% of its gross national product to keep (the National Health Service) going, six times the percentage of 1951. . . . Patients complain their harassed doctors barely have time to hear their symptoms before ushering them out of the office. To meet the doctor drain, Britain is recruiting replacements from India, Pakistan, the West Indies, and other commonwealth countries. They now compose about half of the nation's interns. Hospitals up and down the country have been forced to close emergency departments and recovery wards for lack of staff. The hospitals, themselves, are antiquated, averaging 70 years. Many were originally built as work houses for the poor, and look it. . . . Out of 230 new hospitals projected by 1972, only forty were actually built . . . no one seriously ill lacks skilled and rapid treatment. But for non-urgent cases, patients can wait three months for eye surgery, 22 weeks to have their tonsils removed and even years for such ailments as varicose veins. An average 600,000 patients await urgent surgery at any one time. The British Medical Association estimates that the Health Service needs 1.4 billion dollars immediately to keep pace with inflation. The government gave 96 million dollars." A lengthy dissertation on various aspects of the same problem is given by Nathan Horwitz in a two part article[39,40] appearing in the *Medical Tribune* in November, 1973.

Obviously the cost of national health insurance is determined by the type of legislation that is enacted. Medical care expenditures in European countries have been dealt with by Simanis[68] and Illuminati[41] and further data are available from the World Health Organization.[32] Robert D. Ellers, [27,28] in a two part special article in the *New England Journal of Medicine,* outlines the various types of national health insurance and the relative costs. Kevin P. Phillips,[58] quoting the projected costs laid out in the Department of Health, Education and Welfare's July, 1974, study entitled "Estimated Expenditures Under Selected National Health Insurance Bills, A Report to Congress" cites numerical figures. His article states: "Without legislation, Federal personal health care expenditures were estimated at 26 billion dollars for the 1975 fiscal year. Under the Ullman bill, these would have risen to 45 billion dollars; under the Mills-Kennedy bill, to 69 billion dollars. Under present circumstances this type of new program would worsen the already dangerous budget deficit prospects. In addition, Federal health insurance would promote a second type of inflation—rising medical care demand and costs. This problem was profiled in a 1974 Tax Foundation study on 'Problems and Issues in National Health Insurance.'" Phillips[58] goes on to point out that it is widely acknowledged that Medicare and Medicaid programs were influential in generating sharp price by overstimulating demand for medical and health services relative to the available supplies, combined with the use of financing methods which proved ineffective for controlling price increases.

A key rationale for the establishment of Health Maintenance Organizations is that the patient will receive preventive care in his doctor's office and therefore less hospital care. A recent study by Broida et al[10] suggests that the opposite may be the case. Their study, carried out at the Marshfield Clinic in Wisconsin, showed that prepayment resulted in about 100% increase in ambulatory-care visits, 75% increase in hospital discharges, and 60% increase in hospital days. They pointed out that these increases were far greater than comparable increases in the fee-for-service population served by that Clinic. Here again we find that "use is a function of availability, not of need."[42]

We have little reason to place faith in actuarial data regarding projected government expenditures. It is reported[35] that: "Today, Medicare and Medicaid are helping meeting the health care

needs of 48 million Americans at an annual cost of 26.5 billion dollars. The consensus is that Medicare has succeeded in insulating the aged from ruinous medical expenses but that Medicaid has largely failed to make good health care available to the poor and near-poor . . . Medicare went into effect in July, 1966, and right from the start benefit payments outstripped actuarial projections. During its first year, the program cost 3.4 billion dollars—some four million dollars more than had been predicted. During the year ending this July, outlays are expected to reach 13.7 billion dollars, an amount exceeding the original projection for 1975 by 100 percent."

Can We Afford It?

> *"With the rapid rise in the number of insured patients, as well as medical care costs, especially during the past decades, the problems of financing medical care through health insurance were sharply delineated. It became increasingly clear that no health insurance system could go on paying for all the medical care its members could want without raising expenditure levels beyond what the community was prepared to pay for."*
> J.V. Langendonck[45]

The budget of the United States Government for Fiscal Year 1975[73] states that: "In 1975, Medicare outlays of $14.2 billion will help to meet the medical costs of an estimated 12.2 million aged and disabled Americans, 3.2 million more people than were aided in 1969 . . . Medicaid outlays of $6.5 billions in 1975 will help to pay for medical care for an estimated 28.6 million low-income Americans. This represents a 200% increase in persons helped and a 182% increase in funding since 1969." Each year, the Brookings Institution puts out a book intended as an aid to examination of the budget proposals. This year's publication, entitled "Setting National Priorities, The 1975 Budget,"[7] lists the following under the heading "What Should National Health Insurance Accomplish?"

1. To ensure that all persons have access to care
2. To eliminate financial hardship
3. To limit the rise in health care costs

Let us take these items one at a time. By all odds the most damaging charge that can be leveled against the medical profession is "Because they can't pay for it, hundreds of people around here have to go without needed medical care."[76] This canard should have been laid to rest more than 20 years ago when *Medical Economics* told the story of physicians in Alameda County, California, close to one thousand in number, who made a public guarantee: "No one in Alameda County need ever suffer without medical care through inability to pay."[76] The M.D.'s in this county staged a major advertising campaign and their continuing to publicize that guarantee has lessened such reckless rumors in Alamada County. One day in Honolulu, a disc jockey made the same familiar charges over the air. A medical representative appeared on the disc jockey's program the next morning and challenged him—or anyone else—to name one person in Honolulu who had been denied medical care. The jockey couldn't and had to make a public retraction.[76] Indeed in 1952, the AMA's House of Delegates encouraged constituent state medical societies to make known to the public through every effective medium of communication a guarantee that the services of a physician would be available to all who needed him regardless of ability to pay.[26] So far as the second item is concerned, certainly national health insurance could ensure that no family is forced to suffer severe financial hardship for needed medical care. The financial hardship brought about by increased taxation to pay for national health insurance in the face of inflation generated by the inevitable increase in federal budgetary deficit does not require discussion. So far as national health insurance limiting the rise in health care costs, experience abroad and at home with Medicare and Medicaid would lead one to question this conclusion.

Certainly our Federal Government is in no position to assume a budgetary commitment of this magnitude. We are informed that a deficit as large as $100 billion is possible.[29] J. F. ter Horst[72] informs us that: "The Federal Government's anticipated tax revenues for the new fiscal year, based on the President's proposed budget, averages out to $1,336 for every man, woman and child in the country. Using the Tax Foundation's figures, that amounts to $5,344 in total federal taxes of all types for that hypothetical family of four the statisticians are fond of talking about." Certainly such a program could not be financed through Social Security. Our government's actuarial experts have underestimated the number of elderly people surviving to take advantage of such benefits and have overestimated the number of young people coming into the job market to pay for those benefits. Repeated statements in the press[3,57,77] inform us that Social Security can no longer function on a pay-as-you-go basis and must be subsidized out of general revenue funds.

Conclusions—The Answers To Our Three Questions

> *"But change is not always progress. And the price of these innovations has yet to be measured."* M. K. DuVal[25]

"Naturally, any system that involves collecting money in advance must operate within that fixed amount. If it appears that there may be a deficit, there is a temptation to cut-back on needed service." M. K. DuVal[24]

The answers to our second and third questions—What Will It Cost? and Can We Afford It?—depend upon the answer to the first question—What Are We Going To Purchase? This simple truth—known to housewives in the marketplace for centuries—is a logical guide to any financial transaction.

National health insurance is by no means an all or none proposition. Comparing the services available under national health schemes in various countries reveals broad differences in the services offered and in the manner in which these services are offered. Illuminati[41] has summarized these as follows: "When comparing the figures for the different countries, it must obviously not be overlooked that the protection systems in force (national health services or insurance schemes; direct or indirect provision of benefits) differ from country to country, and that the content of benefits may also vary considerably. For example, in some countries the services of a medical specialist are included in the cost of hospitalization while in others they are not. Depending on the country, hospital treatment may be given without restrictions, or it may be reserved for the most serious stage of the illness. Pharmaceutical benefits may extend to all the medicaments on the market or be confined to those on a special list drawn up by the bodies administering the health service. Medicaments may be issued to a beneficiary entirely free of charge or he may have to pay something towards the cost. In some countries, general medical benefits include dental treatment while in others they do not." Ellers[28] has tabulated the features of a number of different national health insurance proposals being considered in the United States.

Twenty-eight years of British experience with the National Health Service tells us as clearly as if it had been delivered to Moses on Mount Sinai that we should not attempt total Federal financing of cradle-to-grave health care. Even without the lessons learned from Great Britain, our own actuarial experience with Medicare and Medicaid should make this simple truth self-evident. Yet as DuVal[23] tells us: "The issue is that the costs of comprehensive medical care are beyond the reach, financially, of almost all of us. Private health insurance, while it provides some basic coverage for about 80% of our people, has so far not been able to underwrite the bill for all. Clearly then, the existing means of paying for medical services cannot meet the need. . . . There are very few people in the United States today who can afford the cost of a major illness, assuming that all could get the care they needed. High costs in health care are not the result of wrongdoing or sloppy management, although these occasionally may be factors. High costs result from the forces of inflation, the increased sophistication and expense of the biomedical technology that is now available for patient care, and the rising costs of labor, particularly in hospitals." The latter warrants specific mention; in any hospitalization, the non-professional hospital costs are a major factor far in excess of professional costs. Although legislators and third-party fiscal intermediaries have no hesitancy in criticizing professional fees and arbitrarily limiting them, these same parties are conspicuously silent when non-professional employees go on strike and demand higher wages. Accordingly, it does not seem logical to believe that national health insurance will significantly reduce hospital costs.

It would seem then desirable to continue the existing pluralistic health care delivery system of the United States. Advantages of this system include competition between health care delivery systems, governmental scrutiny of the effectiveness of the system, and avoidance of the rigidity of centralized control. What then of the cost of a major illness which few of us could afford? What then of the poor who have no health insurance or, little better, Medicaid, which coverage has at times been farcical? The Washington State Medical Association adopted a policy statement[58] to the effect that any national health insurance plan ought to be health care protection for the poor and catastrophic illness coverage for everybody. This policy statement said further that national health insurance should be built around existing medical and financial resources, preserving the individual's freedom to choose his own physician and hospital. The merit of these proposals seems obvious but the method of financing warrants further clarification. The British experience makes it apparent that prospective reimbursement to area health agencies for regional care rendered by either institutions or provider groups would be undesirable. On the other hand, there should be no objection should certain groups or individuals elect on their own initiative to enter into a capitation-type reimbursement arrangement. Furthermore, it would be as ludicrous as the Indian situation cited by Taylor[71] to reward with increased reimbursement any provider group for decreased utilization. Certainly one cannot condone in any way, care or utilization other than what is thought to be optimum in the eyes of the

provider. Evidence that "use is a function of availability, not of need"[42] has been cited from the British, Italian and Swedish experience. These experiences give credence to the statement by Ellers[27] that: "Consumer participation in the financing also allays the impression of some consumers that the program in effect costs them nothing . . . . The bulk of those covered by national health insurance should participate in paying for their services to the extent necessary to encourage their responsible use of services and to minimize the administrative costs associated with obtaining health care."

Inseparable from the question of availability of health care is the question of the alleged physician shortage. Few informed individuals would dispute that rather than a physician shortage, there is a maldistribution of physicians as to geography and as to specialty superimposed upon some component of malutilization. Yet the solution to this problem does not lie in national health insurance. A dearth of physicians in less populous areas is a problem in many parts of the world. Illuminati[41] has demonstrated that a national health scheme does not in itself resolve the problem. The means of attacking this problem, already at hand, are multiple. These include improved methods of transportation (i.e., helicopters), physicians' assistants under the supervision of physicians, control by specialty societies and specialty Boards of the number of specialists being trained, and, most importantly, incentives for individual physicians to engage in family practice and to practice in more remote areas where physicians are needed. These incentives—far preferable to federal mandate—might include scholarships to medical schools for individuals willing to practice for a given period of time in a remote area, as well as a major income tax deduction for those engaging in family practice and those practicing in remote areas.

Thus it is that evidence from abroad and at home dictates overwhelmingly that minor alterations in the existing pluralistic health care delivery system can correct many of the deficiencies that exist whereas substituting an entirely new system can lead only to disaster. If we do not learn from the so-clearly evident mistakes made in the past, certainly we are doomed to repeat these mistakes in the future. We can only hope that our governing officials, who apparently did not learn from the British success in Malaysia prior to our tragic misadventure in Indochina, will learn from the British mistakes in Great Britain rather than leading us into another tragic misadventure here in the United States.

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Ed. Note: Dr. Mosberg is President of the Medical Alumni Association and Professor of Neurological Surgery, University of Maryland School of Medicine. Dr. Nelson is Clinical Associate Professor of Neurological Surgery, Texas Tech School of Medicine, El Paso.

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OLD PHOTOS, ANYONE?

The Office of University Relations at the University of Maryland at Baltimore (UMAB) is looking for old photographs of the downtown campus.

Interesting photographs of street scenes, classroom scenes and special events dating from the 1800's through present-day are being sought.

These photographs will be used in publications and special projects, i.e., displays and slide shows, for the seven professional schools—dental, graduate, law, medicine, nursing, pharmacy, social work and community planning—and the University of Maryland Hospital.

Original photographs will be returned to the owner, and a description of the picture and the owner's name will be recorded.

Photographs and descriptions should be sent to: Phil Szczepanski, University Photographer, University of Maryland at Baltimore, 511 W. Lombard Street, Baltimore, Md. 21201.

Those persons desiring to bring the photos to the campus to be copied "on the spot" can make appointments by calling (301) 258-7820.

University of Maryland at Baltimore
BICENTENNIAL WALKING TOUR

The University of Maryland had its beginning on the Baltimore campus with the founding of the fifth oldest medical school in the country, the School of Medicine, in 1807. In the ensuing 169 years, six other professional schools have been added to the Baltimore campus.

During the Bicentennial, the Office of University Relations has arranged a tour including (1) Health Sciences Library Historical Room; (2) Davidge Hall; (3) Westminster Churchyard; (4) Museum of the Baltimore College of Dental Surgery; (5) St. Paul's Cemetery; (6) B. Olive Cole Pharmacy Museum; (7) University of Maryland Hospital.

In conjunction with the walking tour, four paintings (pictured below) will be on display at University Hospital depicting the hospital—circa 1820, 1880 and 1930, and Davidge Hall.

Watch for an announcement shortly regarding the purchase of a series of the limited edition of color prints of these paintings, signed by the artists. These prints will be suitable for framing and a handsome addition to any library or office.

RETURNING ALUMNI: Literature regarding the walking tour will be available during Alumni Day—don't miss this opportunity to see some old and new sites on the campus.

A History of the Division of Neurological Surgery At the University of Maryland Hospital

James G. Arnold, Jr., M.D.

Neurological surgery at the University of Maryland Hospital was established as a division of surgery in 1930. Prior to this there was very little surgical specialization, but our Professor of Surgery, Dr. Arthur M. Shipley, felt that the time had come when surgical problems of the nervous system warranted specialized attention. Dr. Shipley approached Dr. Charles Bagley, Jr. about developing this specialty field, and Dr. Bagley agreed, subject to the provison that all head injuries be the responsibility of the neurosurgeon. Thereupon, Dr. Bagley and his associate, Dr. Richard G. Coblentz, set about establishing what is now the Division of Neurological Surgery.

For a number of years prior to 1930, Dr. Bagley had pursued his research projects in the Phipps Clinic at the Hopkins Medical School. When he began to develop the neurosurgical division at the University of Maryland, he agreed to transfer his research here, and one of the early neuropathological laboratories in the country was thus established. In addition to the research activities, the laboratory had the responsibility for the routine examination of the neurological material from the operating room and from autopsies. Dr. William Geraghty assisted in the early development of this laboratory, and I joined him in 1932. From 1932-34, I devoted my full-time effort to his area, and on a part-time basis until the spring of 1939, when the direction of the laboratory was taken over by Dr. Edward Cotter. When Dr. Cotter left for World War II, he was succeeded by Dr. John Wagner, who became the director of the laboratory on a full-time basis. In due course, Dr. Wagner was promoted to Professor and Chairman of the Division of Neuropathology, a post which he held with distinction until his retirement in 1974. This division is now headed by Dr. Julio Garcia.

In the early stages of its development, the neurosurgical division functioned largely in name only. Beds for neurosurgical patients came from a general pool. The house staff consisted of trainees from general surgery who rotated for short periods, and occasionally a neurosurgical trainee from another hospital would spend a short time on the service. In the operating room, we had to rely on the general anesthesiologists, and our operative assistants were nurses who rotated on the service every two weeks.

Anesthesia in those days was a particular nightmare, since the new specialty presented problems far different from those in general surgery. Endotracheal anesthesia had not yet been introduced, and the higher mortality rate at that time was due more to poor anesthesia than to the operative procedure. Many operations were done in the prone position, and I can well remember Miss O'Brien literally sitting on the floor pumping ether fumes uphill. This was known as "working under the sheet." There was obviously no way to correct tracheal obstruction, should this occur. Anesthesia has, of course, made its own progressive contributions, and in 1971, neurosurgery at the University was given a significant boost: Dr. Jane Matjasko was assigned to the division as full-time neurosurgical anesthesiologist. Her expertise is outstanding, and she has added immeasurably to the advancement of new techniques in this field.

It was not until 1940 that we had our own operating room nurse, and I well remember how this occured. It was during my residency training, and one day I was called to Dr. Shipley's office, where he proceeded to chew me out: "Arnold, if you don't stop being tempermental and throwing instruments, I'll have to fire you." (Dr. Shipley delighted in firing residents and rehiring them the next day.) I replied, "I'll make you a promise. If you give us our own nurse, I'll stop throwing instruments." Shortly thereafter, we were extremely fortunate in obtaining the services of Miss Nora Edwards (now Mrs. John Wagner), who had been supervisor of the operating room at the Union Memorial Hospital. Since then we have continued to have a full-time supervisor for our neurosurgical operating rooms.

The beginning of the residency training program was in 1937, when Dr. William W. McKinney decided to specialize in neurological surgery. His interest in this field was stimulated when he came to the University as an assistant resident in surgery, being assigned to orthopedics and neurosurgery. He spent one year on this assignment, but during the remainder of his training period he devoted all his time to the neurosurgical service. In 1939, when I entered the training program, it consisted of one resident and a rotating intern, as compared with the present staff of ten full-time residents. Since 1937, the division has trained 43 neurosurgeons, 16 of whom are now practicing in Baltimore. The present training pro-

gram spans a period of five years. The first year is divided between Shock Trauma and the Neurophysiology Laboratory. The trainee is given three years of clinical neurosurgery, six months of which he spends at Mercy Hospital which has been an affiliate for many years. His training also includes six months in Neuropathology and a half year in Clinical Neurology at the National Hospital in London.

A significant breakthrough in neurosurgical nursing care occurred in 1961 when the division was given a segregated neurosurgical ward in the Psychiatric Building. The ward contained 25 beds, and this was the beginning of an organized nursing staff. Miss Rita Malik supervised the ward activities as well as the operating rooms, and she was able to recruit nurses for this special area. Following the resignation of Miss Malek, Mrs. Juanita Jones continued to do an outstanding job. She was later promoted to Assistant Director of the operating room, and we now have the good services of Mrs. Kathryn Donnelly.

The tremendous advantage of a segregated patient area was well demonstrated during our years in the Psychiatric Building. After the division was moved to the 9th floor of the general hospital in 1965, and as the other services expanded, the neurosurgical beds were gradually decreased. Once again, a conglomerate of patients was admitted to the neurosurgical area, resulting in a marked disruption of our nursing morale as well as a severe reduction in neurosurgical admissions. It was not until late 1973, when we moved to our present quarters in the new hospital, that we were able to re-establish a segregated patient area, as well as specialized nursing staff, which is now under the very capable direction of Mrs. Constance Wallach. In addition, we have an ultra modern, 7-bed Intensive Care Unit, with computerized monitoring. This area is under the supervision of Miss Elizabeth Montgomery, who is doing an outstanding job.

Diagnostic neuroradiology has kept pace with our progress in clinical surgery. In the early days, diagnostic procedures were done entirely by the neurosurgical staff in the old Radiology Department. We were later able to obtain equipment and establish a diagnostic room on the operating floor, and the neurosurgical staff continued to do their own diagnostics until Dr. John Hearn joined the Radiology Department. Dr. Hearn had a special interest in neuroradiology, and during his tenure we saw significant progress in this field. When he resigned in 1972 to go into private practice, we were very fortunate to have Dr. Powell Williams appointed as Head of the Division of Neuroradiology. Under his direction further significant progress has been made. We now have two diagnostic rooms on the operating floor with the very latest equipment, including the recently acquired EMI scanner.

From the beginning of the division, our main effort has been in the realm of clinical practice, clinical research, and residency training. However, Dr. Raymond K. Thompson has supervised a small basic research laboratory, but due to lack of facilities we were not able to expand this area until recently. In 1972, a full-time research physiologist was added to our staff. He is Dr. Richard Schneider, who obtained his Ph.D. from the University of Pittsburgh. Since Dr. Schneider joined us, the neurophysiological laboratory has been enlarged, and we feel that the further development of this area will add a new dimension to the service.

The Division of Neurological Surgery was directed by Doctors Bagley and Coblentz until Dr. Bagley's retirement in 1952, at which time I became Acting Head. Also in 1952, Dr. Robert M. N. Crosby was given the responsibility for the development of pediatric neurosurgery at the University and Mercy Hospitals, and his contribution has been outstanding. In 1954, I was appointed to the Chairmanship of the division and continued in this capacity on a part-time basis until 1970. At that time Dr. Ronald L. Paul was appointed to the full-time staff, and two years later, because of the increasing demands of the Shock Trauma Unit, he was joined by Dr. James E. Dunn, II. Unfortunately, however, the lure of private practice eventually resulted in the resignation of both Doctors Paul and Dunn, so that in January of 1974, I joined the staff on a full-time basis. Following my retirement in July, 1975, the division will be headed by Dr. Thomas B. Ducker. Dr. Ducker received his neurosurgical training at the University of Michigan, following which he became Associate Professor of the Department of Surgery at the Medical University of South Carolina in Charleston.

In conclusion, I would like to express my deep appreciation to our voluntary staff, who have contributed so much to the present state of excellence which the division has achieved: Dr. Raymond K. Thompson, Dr. John O. Sharrett, Dr. Israel H. Weiner, Dr. Paul C. Hudson, Dr. Charles M. Henderson, Dr. G. Lee Russo, Dr. Paul D. Meyer, Dr. Robert G. Hennessy, Dr. Ronald L. Paul, Dr. Fred N. Sugar, Dr. Edward D. Layne, Dr. Jorge R. Ordonez, Dr. Charles J. Lancelotta, Jr., and Dr. David M. Cook.

ED. NOTE: Dr. Arnold at the time of the writing of this article was Professor and Chairman of the Division of Neurological Surgery at University of Maryland Hospital.

PRESIDENT'S MESSAGE

William H. Mosberg, Jr., M.D.

"One of the great aggravations of a historian's life is the number of people he encounters who think history began the day they were born . . ." J. P. Roche[6]

I wish to devote my last message as President of this Association to an expression of appreciation to the members of this Association for granting me the honor of serving as its President during the past year. More than that, however, on behalf of all Alumni, I wish to express appreciation to members of the Medical School Faculty — past and present — for their dedication, patience, and persistence in making us the physicians that we are today. Particularly, I wish to express appreciation to the part-time faculty members — most of whom are quite senior by now and many of whom unfortunately are deceased — who gave unselfishly of their time, always without financial reimbursement and often without even a verbal expression of appreciation.

Shortly after his arrival on the scene, a recent Dean of this Medical School was quoted in the lay press[5] as stating that his predecessor ". . . in the last fifteen years has taken this school out of the doldrums." This remark was intended to compliment his predecessor on the calibre of his leadership and the magnitude of his contributions. Undoubtedly it was not intended that this remark should have been offensive, but it could have been — and indeed was — taken as insulting by some faculty members with a record of many years of distinguished contributions to the School of Medicine. Beginning a few years after World War II and extending through the 1950's there occurred a transition from a part-time non-salaried faculty to a full-time salaried faculty. Unfortunately, in the haste to effect this transition replacing senior part-time faculty with a full-time salaried counterpart, all too often the customary courtesies and amenities were overlooked and appropriate cognizance was never taken of the years of dedicated service of many of these departing faculty members. At this late date — tragically too late for some — I wish to rectify this deficiency.

In the Department of Medicine, many physicians practicing today owe their knowledge of medicine to men such as Maurice Pincoffs, T. Nelson Carey, Thomas Sprunt, Edward Cotter and Wilfred Townshend, each of whom served for many years at the University of Maryland Hospital. Similarly, at Mercy Hospital we are indebted to men such as H. Raymond Peters, Sheldon Eastland and David Tenner. Harry Robinson, Sr. took great pride, as did his sons in later years, that University of Maryland graduates were second to none in their knowledge of Dermatology. Who can forget the inspiring Cardiology lectures given by T. Conrad Wolff or the breadth of knowledge of Louis Krause? We were indebted for our knowledge of Surgery to men such as Arthur M. Shipley, C. Reid Edwards and George Yeager as well as Harry Hull and Thurston Adams. Fortunately, the latter two are still with us. At Mercy Hospital we were similarly indebted to men of the calibre of Walter Wise and Daniel J. Pessagno. In those days, with a course in Surgical Anatomy in the second year and Operative Surgery in the Junior year, we benefitted from the knowledge and experience of many prominent surgeons including Otto C. Brantigan, William B. Settle, W. Wallace Walker, Herbert Reifschneider, Harry Bowie, Robert Healy, George Govatos and Karl Mech. Of these, we were particularly indebted to Dr. Brantigan, who not only taught us Surgical Anatomy but also devoted an unbelievable amount of time (for which he has never been thanked adequately) in his capacity as Chief of Surgery at the Baltimore City Hospitals, as

did his predecessor, Thomas Aycock. Cognizance should also be taken of the many years of service of Drs. Voshell, Ullrich, and Cotton in Orthopedics; Drs. Clapp and Knowles in Opthalmology; Drs. Looper, O'Rourk, and Rich in Otolaryngology; Drs. Toulson, Hogan, Mays and Gillis in Urology; and in my own specialty, Drs. Bagley, Coblentz, Arnold, and Thompson. For our knowledge of Radiology, we were indebted to Drs. Walton, Kilby, and Davidson; and in Psychiatry, we learned from men such as Dr. Truitt and Dr. Hohman. The Pediatricians were a devoted group and included names such as Drs. Joslin, Bradley, Seabold and two who are still with us — Dr. Finkelstein and Dr. Glick. One would be hard pressed to equal — much less exceed — the calibre of teaching we received in Obstetrics and Gynecology. In Obstetrics we were exposed to the formidable array of men such as Drs. Douglass, Reese, Savage, Kaltreider, McNally, Dixon, Seigal, and Morrison. The roll call of talent in the Department of Gynecology was no less impressive and included names such as Drs. Hundley, Diggs, Kardash, Diehl, Dumler, Cornbrooks, Compton, and the internationally-renowned Dr. Emil Novak. The names of those who headed the preclinical departments are legendary: Eduard Uhlenhuth, Frank Figge, Carl Davis, H. Boyd Wylie, Frank Hachtel, John Krantz, William Amberson, and Hugh Spencer.

There are others with whom our contacts were more limited but of whom our memories are as indelible. We remember the incisive comments of Monte Edwards, the joviality of Luther Little, the dry humor of the late C. Parke Scarborough, the spot diagnoses of Samuel Legum, and the ability of Sam Revell to identify a spade as a shovel. We were equally impressed with the mental agility of John Legge, the historical aptitude of Margaret Bullard, the public health lectures of Huntington Williams, the quiet and yet authoritative manner of Lawrence Serra, the endocrinologic teachings of Harvey Beck, the dedication of Kurt Levy, and the tireless work capacity of the late Edward A. Kitlowski. Others of the then younger men who are still actively with us include: S. Edwin Miller, James Karns, Ephraim Lisansky, Joseph Muse, William Fearing, Patrick Phelan, Leon Ashman, and Edward Leach.

To all of those I have listed above, and with sincerest apologies to any I may have overlooked, I offer — albeit somewhat belatedly — our heartfelt gratitude for the many hours and years you have given so unselfishly of your time to enable us to become physicians. Also, let me assure you that the only time we felt as though we were "in the doldrums" was when Dr. Uhlenhuth told us that we had not studied our Anatomy.

At the present time we are fortunate to have an outstanding faculty in our Medical School and a Dean whose allegiance to and interest in the School of Medicine is total. With this combination the future inevitably must be bright. Let us though realize that none of what we have or will have could be possible without the foundation built by the generations which preceded us. Our past history, readily available to the interested reader, [2,3,4,8,9] is a glorious one in which we may take justifiable pride.

References

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4. Hull, H. C., Professors of surgery 1807-1970 (part two). Bull. School Med. Univ. Maryland, 56:44-52, Oct., 1971.
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6. Roche, J. P., Your birth didn't start history—No Sir! The News American, 5B, Oct. 5, 1975.
7. Smyth, W. B., New UM medical dean asks greater social involvement with community. The Sun, CI, June 24, 1969.
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STOP KILLING YOURSELF

Peter J. Steincrohn, M.D.

AUTO SAFETY

Dear Dr. Steincrohn: I've never read a column of yours that discussed auto safety. I am personally interested since a brother-in-law was killed a few weeks ago in a car accident.—Mr. T.

COMMENT: There have been many columns about this. Probably there should have been more. For death and suffering are tragic wherever you find them. In bed, or on the road.

The bedridden cancer patient is as pitiful as the one knocked senseless by a car. Illness is not a pretty picture when the odds against survival are zero.

But what makes such fatalities even more horrible is the simple, bare truth that so many might have been saved from themselves. For example, the cancer patient getting to the doctor in time to overcome the threat; the auto driver, knocking enough common sense into his head to refuse to load up on alcohol before slipping behind the wheel of his car.

Unlike Ralph Nadar, who has done so much to improve auto safety by being the gadfly who thrust life-saving devices on the auto manufacturers, I believe that the personal element (the driver himself) is the greater menace on the road.

You are a danger to yourself if you refuse to use your seat belt. If you drive when angry and upset. If you take tranquilizers or antihistamines before a long trip. If you take stronger drugs. If you are simply an offensive, rather than a defensive driver by nature.

But your greatest danger to yourself and others is taking alcohol before you drive. One estimate is that over 25,000 were killed and over two million maimed and injured last year due to alcohol.

Alcohol. This is our common enemy. Every day we go to battle in this cold war (which inevitably turns hot) between man and machine.

I blame our losing battle on the courts. They are too lenient. Penalties are not severe enough.

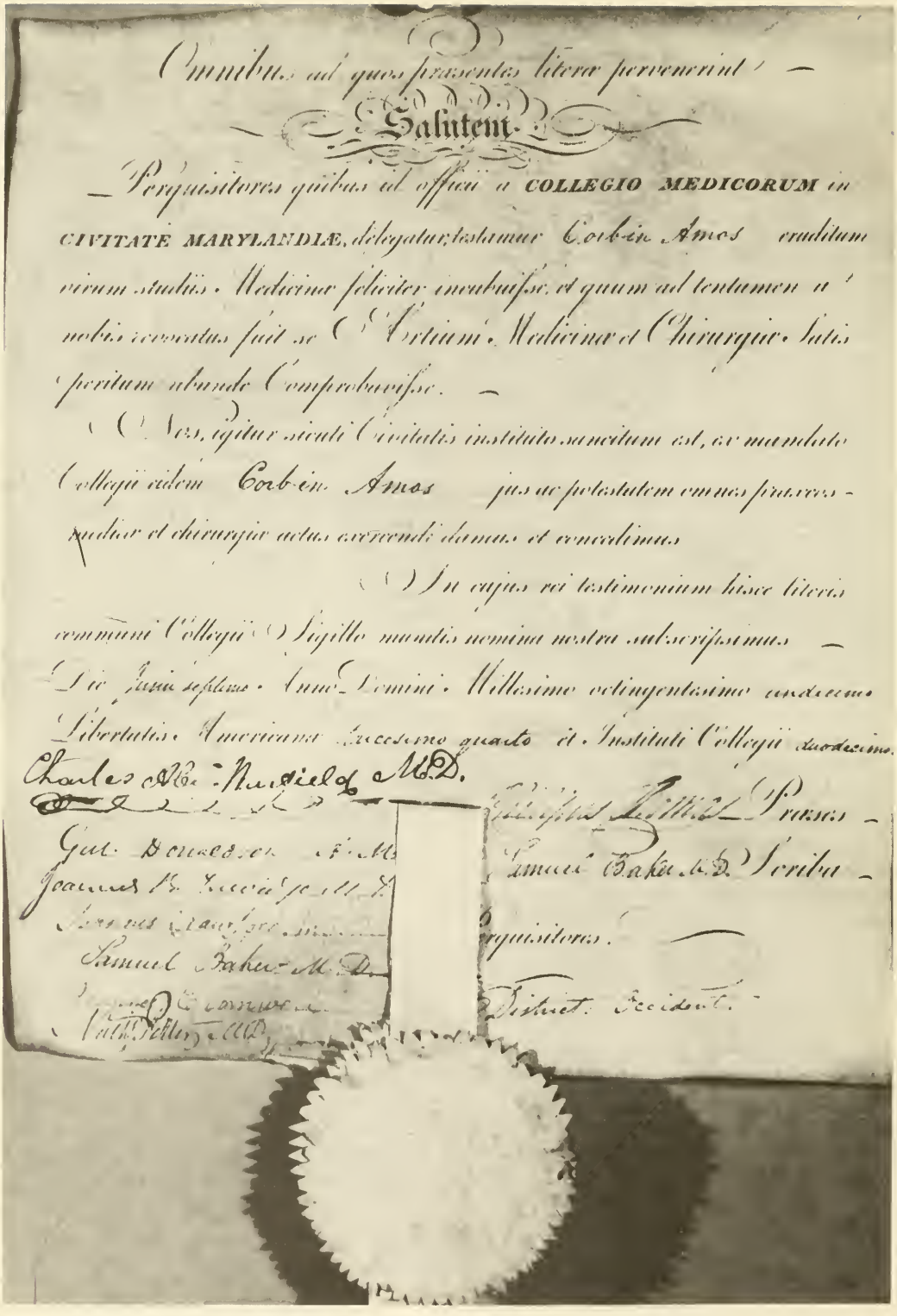
In Finland, for example, you'd get up to six months in jail if any alcohol was found in your system while driving—accident or not. In the United States, even chronic alcoholics who have wounded and killed are let loose with suspended sentences to roam the roads and maim and kill again.

If you had a stiff penalty hanging over you, chances are you'd use your hands for only buckling your belt before driving—and not use them to mix a highball.

The time to take a drink, if you want one, is AFTER you get home and not before.

ED. NOTE: Peter J. Steincrohn, Class of 1923, University of Maryland School of Medicine, who has been living in Coral Gables, Florida since 1956, has had an unusually diversified career in medical writing. In addition to having had articles published in scientific journals, he has had many articles published on medical topics in lay journals. The variety of books that he has had published attests to an exceptionally effective approach from the viewpoint of the lay reader and his comprehension of medical problems.

Dr. Steincrohn has kindly given us permission to publish several excerpts from his writings. Currently, Dr. Steincrohn is working on another book and is writing a column that appears in several daily newspapers, including the Baltimore Evening Sun.


Omnibus ad quos præsentes literæ pervenerint —
Salutem.
Perquisitores quibus ad officii a COLLEGIO MEDICORUM in CIVITATE MARYLANDIÆ, delegatur, testamur Corbin Amos eruditum virum studiis Medicinæ feliciter invacuisse et quum ad tentamen a nobis recepta fuit se Artium Medicinæ et Chirurgiæ satis peritum abunde comprobavisse —
Vos, igitur secundi Civitatis instituta sancitum est, ex mandato Collegii eidem Corbin Amos jus ac potestatem omnes præscriptas artes et chirurgiæ actus exercendi damus et concedimus
In cujus rei testimonium hisce literis communi Collegii Sigillo munitis nomina nostra subscripsimus —
Die Junii septimo Anno Domini Millesimo octingentesimo undecimo Libertatis Americanæ Decessimo quarto et Instituti Collegii duodecimo.
Charles Ridgely M.D.
Gul. Donaldson
Joannes B. Davidge
James Craufurd
Samuel Baker M.D.
Perquisitores.
Attest. Secret.

The 1977 graduating class will be eagerly awaiting the presentation of their diplomas from the University of Maryland School of Medicine just as Dr. Corbin Amos did in 1811. (Courtesy of the Archives of the Medical Alumni Association, University of Maryland School of Medicine)

101st Medical Alumni Reunion
SCHEDULE

Wednesday, June 2, 1976

7:00 p.m.	Registration and Reception Hunt Valley Inn
8:00 p.m.	Dinner Program (Guest Speaker to be announced) Presentation of 50-Year Certificates
	Dancing to Mel Scherr's Orchestra

Thursday, June 3, 1976

9:00 a.m.	Registration and Refreshments Chemical Hall, Davidge Hall
10:00 a.m.	Welcoming Remarks:
	William H. Mosberg, Jr., M.D., President Medical Alumni Association
	John M. Dennis, M.D. Dean of the School of Medicine and Vice Chancellor for Health Affairs
	Albin O. Kuhn, Ph.D., Chancellor University of Maryland at Baltimore
10:30 a.m.	Scientific Program:
	Blaine Taylor, Managing Editor, Maryland State Medical Journal; "Health and History — How Illness of Leaders Changed the World"
	Roger H. Michael, M.D., Associate Professor of Orthopaedic Surgery, University of Maryland School of Medicine, narrated slide presentation on "Sketches of Davidge Hall and its Founder"
11:45 a.m.	Presentation of 25-Year Certificates
12:00 Noon	Annual Business Meeting
1:00 p.m.	Luncheon Circle One Restaurant Holiday Inn, Lombard and Howard Streets
3:00-5:00 p.m.	**Department of Obstetrics and Gynecology** Open House Room 6-1012, University of Maryland Hospital
6:00-11:00 p.m.	Cocktail Reception (Hot and Cold Hors D'oeuvres) Davidge Hall

Friday, June 4, 1976

10:00 a.m.	Pre-commencement Exercises Lord Baltimore Hotel
3:00 p.m.	Commencement Exercises Baltimore Civic Center

LADIES ACTIVITIES

All ladies are cordially invited to attend the Annual Reception and Banquet on Wednesday, June 2, 1976 at the Hunt Valley Inn, as well as the Cocktail Reception to be held on Thursday evening, June 3, at Davidge Hall.

Tour and Luncheon
Thursday June 3, 1976

9:00 a.m.	Board bus at Hunt Valley Inn
9:30 a.m.	Board bus at University Hospital (Hospital Circle)
9:45 a.m.	Depart for guided Baltimore Bicentennial Tour including: historic Federal Hill; highest vantage point in the city overlooking the port and the new Inner Harbor area; a drive through Bolton Hill with its elegant 100-year old townhouses; Mt. Vernon Square, known as one of the most beautiful squares in America, with a stop at the Peabody Library noted for its tiers of iron-face grillwork balconies; tour of Hampton House, on the edge of Green Spring Valley, known as one of the great post-Revolution mansions of late-Georgian style architecture. Following the tour, a sherry-luncheon will be served in the "old Maryland manner" in the Hampton House garden.
1:30 p.m.	Bus departs for Hunt Valley Inn, then to University Hospital

TENTATIVE COURTESY BUS TRANSPORTATION SCHEDULE

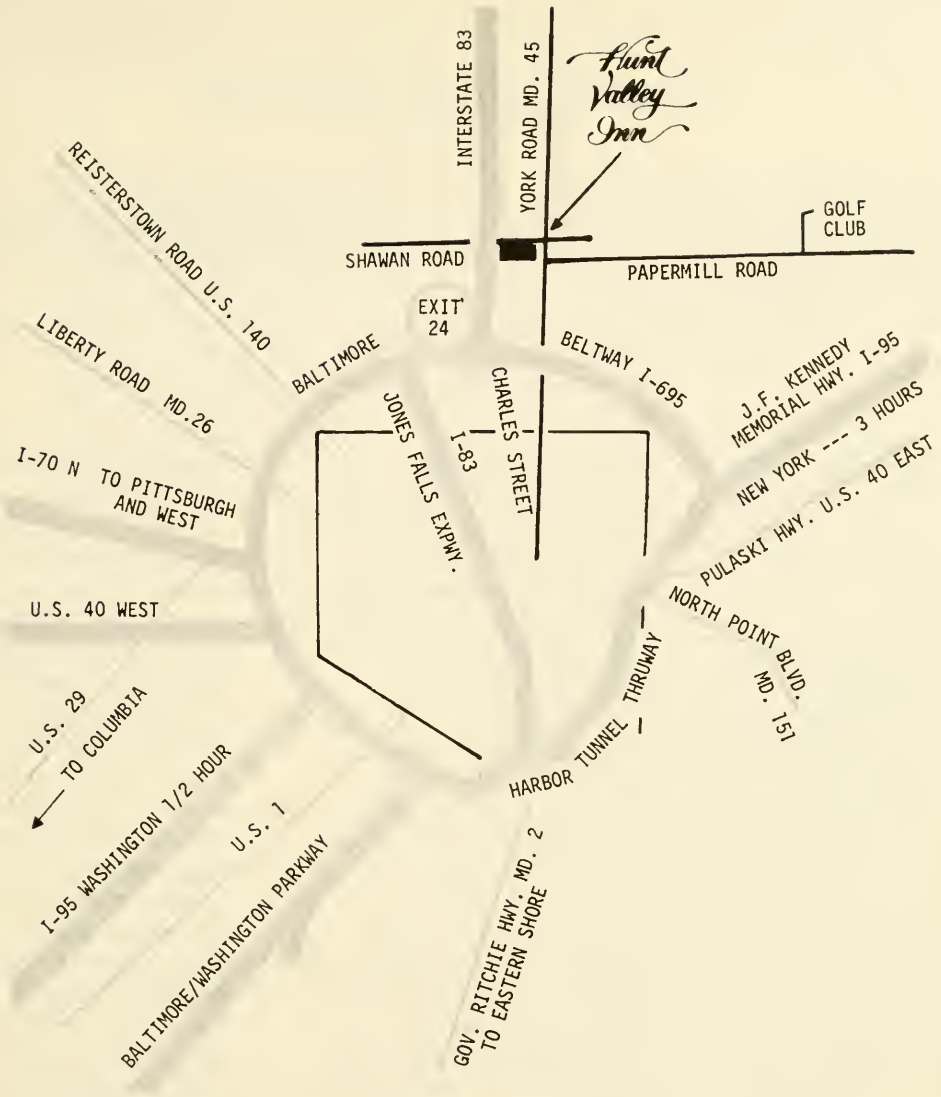
Wednesday, June 2, 1976

6:15 p.m.	University Hospital to Hunt Valley
11:30 p.m.	Hunt Valley to downtown Baltimore
1:00 a.m.	Hunt Valley to downtown Baltimore

Thursday, June 3, 1976

8:15 a.m.	Hunt Valley to University Hospital
9:00 a.m.	Ladies board bus for tour and luncheon (Hunt Valley)
9:30 a.m.	Ladies board bus for tour and luncheon (University Hospital Circle)
1:30 p.m.	Ladies return to Hunt Valley Inn and University Hospital
2:30 p.m.	University Hospital to Hunt Valley

Depart Hunt Valley Inn	Depart University Hospital (Hospital Circle)
5:15 p.m.	6:30 p.m.
7:15 p.m.	8:00 p.m.
8:45 p.m.	11:00 p.m.



HOTEL ACCOMMODATIONS

Hunt Valley Inn
Interstate 83 at Shawan Road
Hunt Valley, MD 21031
Phone: 301/666-7000

Holiday Inn—Downtown
Lombard and Howard Streets
Baltimore, MD 21201
Phone: 301/685-3500

Lord Baltimore Hotel
Baltimore and Hanover Streets
Baltimore, MD 21203
Phone:301/539-8400

The Baltimore Hilton
101 W. Fayette Street
Baltimore, MD 21201
Phone: 301/752-1100

PARKING FACILITIES

Thursday morning, June 3, 1976	Pratt St. Garage (entrance on Penn St., between Lombard and Pratt)
Thursday evening, June 3, 1976	Law Lot (entrance on Redwood St., across from Visitors' Parking Lot); if full: Pratt Street Garage

101st Reunion Activities

The Board of Directors of the Medical Alumni Association wishes to announce that for the first time certificates will be awarded alumni in recognition of their 25 years of service in the medical profession.

Individual certificates will be presented to the following alumni at the Annual Business Meeting on Thursday, June 3, 1976.

Class of 1951

Law A. Ager, M.D.
Robert K. Arthur, Jr., M.D.
John P. Barthel, M.D.
Earl M. Beardsley, M.D.
Arthur K. Bell, M.D.
Joseph Bilder, Jr., M.D.
Beverly R. Bireley, M.D.
Nancy Blades, M.D.
John Wesley Bossard, M.D.
John V. Brannon, M.D.
John R. Buell, Jr., M.D.
Russell L. Christopher, M.D.
Raymond L. Clemmens, M.D.
Kaohlin M. Coffman, M.D.
Solomon Cohen, M.D.
Raymond R. Curanzy, M.D.
Joseph Deckelbaum, M.D.
Ernest A. Dettbarn, M.D.
Leon Donner, M.D.
Winston C. Dudley, M.D.
George M. Dunn, M.D.
William A. Dunnigan, M.D.
David E. Edwards, M.D.
William G. Esmond, M.D.
Otis D. Evans, Jr., M.D.
Charles K. Ferguson, M.D.
Joseph C. Fitzgerald, M.D.
Rowland E. J. Fullilove, M.D.
James P. Gallaher, M.D.
Mario R. Garcia Palmieri, M.D.
Francis S. Gardner, Jr., M.D.
John B. Gates, M.D.
Benjamin D. Gordon, M.D.
Frederick J. Hatem, M.D.
George J. Iten, M.D.
Frederick M. Johnson, M.D.
Wallace E. Johnson, M.D.
Paul E. Kashel, M.D.
William F. Kindt, M.D.
David M. Kipnis, M.D.
Harry L. Knipp, M.D.
Howard C. Kramer, M.D.
William E. Lamb, M.D.
Theodore R. Lanning, M.D.
Jack Leibman, M.D.
Leo H. Ley, Jr., M.D.
Leonard M. Lister, M.D.
James M. MacDonald, Jr., M.D.
Earl B. McFadden, M.D.
John W. McFadden, M.D.
Charles W. McGrady, M.D.
Kathleen R. McGrady, M.D.
Ricardo T. Mendez Bryan, M.D.
John S. Metcalf, Jr., M.D.
Robert S. Mosser, M.D.
Arthur Z. Nutter, M.D.
Donald J. Myers, M.D.
Edward J. Nygren, M.D.
John S. Orth, M.D.
Douglas R. Packard, M.D.
Doris M. Harris, M.D.
F. Robert Perilla, M.D.
Henry D. Perry, Jr., M.D.
Henry G. Reeves, Jr., M.D.
Eugene B. Rex, M.D.
Georgia M. Reynolds, M.D.
Aubrey D. Richardson, M.D.
Marvin J. Rombro, M.D.
Harry S. Rowland, Jr., M.D.
Armando Saavedra, M.D.
Arthur H. Schmale, Jr., M.D.
Roger D. Scott, M.D.
John T. Scully, M.D.
William H. Shea, M.D.
Samuel N. Sherry, M.D.
L. Dale Simmons, M.D.
Edward M. Sipple, M.D.
R. Kennedy Skipton, M.D.
David M. Solomon, M.D.
John H. Stone, M.D.
Julian T. Sutton, M.D.
Richard B. Tobias, M.D.
Homer L. Twigg, Jr., M.D.
Melvin M. Udel, M.D.
Robert J. Venrose, M.D.
Charles P. Watson, Jr., M.D.
Robert D. Weekly, M.D.
Harvey P. Wheelwright, M.D.
Charles R. Williams, M.D.
Shelly C. York, Jr., M.D.
Thomas L. York, M.D.

Note to 1951 Class Members: if you are unable to attend the Annual Business Meeting on Thursday, June 3, 1976, please notify the Alumni office so that your certificate can be mailed.

On the evening of Wednesday, June 2, 1976 at the Hunt Valley Inn, the following members of the Class of 1926 will be honored and presented individual certificates commemorating their 50th Anniversary of graduation from the University of Maryland School of Medicine.

Class of 1926

John A. Askin, M.D.
Margaret B. Ballard, M.D.
Jack H. Beachley, M.D.
Antonio F. D'Angelo, M.D.
H. Elias Diamond, M.D.
Newman H. Dyer, M.D.
Julian C. Elliott, M.D.
Harold H. Freedman, M.D.
Isadore E. Gerber, M.D.
David M. Helfond, M.D.
Phillip Johnson, M.D.
Meyer S. Jolson, M.D.
Louis T. Lavy, M.D.
H. Edmund Levin, M.D.
I. Leonard Levin, M.D.
Joseph Levin, M.D.
Lloyd U. Lumpkin, M.D.
Frank F. Lusby, M.D.
Albert F. Moriconi, M.D.
H. Maxwell Fields, M.D.
Abraham S. Rothberg, M.D.
Paul Schenker, M.D.
William Schuman, M.D.
Elizabeth B. Sherman, M.D.
Maurice L. Teitelbaum, M.D.
Max Trubek, M.D.
Louis L. Weiss, M.D.
Louis J. Weseley, M.D.

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1921 Moses Paulson, M.D.
11 East Chase Street
Baltimore, MD 21202

1926 Louis T. Lavy, M.D.
6414 Park Heights Avenue, D-4
Baltimore, MD 21215

1931 William M. Seabold, M.D.
Arthur G. Siwinski, M.D.
Co-Chairmen
c/o Medical Alumni Association, M.D.
522 W. Lombard Street
Baltimore, MD 21201

1936 Gibson J. Wells, M.D.
5618 St. Albans Way
Baltimore, MD 21212

1941 Pierson M. Checket, M.D.
4024 Essex Road
Baltimore, MD 21207

1946 James A. Roberts, M.D.
8907 Georgia Avenue
Silver Spring, MD 20910

1951 William G. Esmond, M.D.
800 Country Club Road
Havre de Grace, M.D. 21076

1956 G. Edward Reahl, Jr., M.D.
411 N. Charles Street
Baltimore, MD 21201

1961 Francis A. Clark, Jr., M.D.
Maryland General Hospital
827 Linden Avenue
Baltimore, MD 21201

1966 Richard M. Susel, M.D.
3455 Wilkins Avenue, Suite 208
Baltimore, MD 21229

1971 George H. Brouillet, Jr., M.D.
2-E Ginger View Court
Cockeysville, MD 21030

ALUMNI CHATTER

Robert C. J. Krasner, '71, London, England, served his internship and residency at the New England Medical Center Hospital in Boston. In July, 1973, he left for a year in Ethiopia with the USN as a physician and surgeon in Asmara to DOD, DOS personnel and to members of the Imperial Ethiopian Family. He served there during the last MidEast war and the beginning of the coup. In July, 1974, Dr. Krasner left to become Senior Medical Officer in La Maddalena, Sardina, Italy. In July, 1975, he arrived at the U.S. Embassy in London as a physician to DOD, DOS, Ambassador Richardson and family and staff, CINCUSNAVEUR, and other government personnel in London. Over the past two and a half years since he left Boston he has been to Kenya, Sudan, Egypt, Tanzania, USSR, Greece, Turkey, and France as well as travelled extensively all over Ethiopia, Italy, and the United Kingdom for the government or for personal reasons. He expects to stay in London until July, 1977 when he will return to the U.S.

• • •

Elliot Cohen, '68, Heidelberg, Germany, is Chief of the Mental Hygiene Consultation Service, Department of Psychiatry, U.S. Army Hospital, Heidelberg. He served his residency in Psychiatry at the Institute of Psychiatry and Human Behavior, University of Maryland School of Medicine from 1972-75. He and his wife will be stationed in Heidelberg until July, 1977 when they will then move to California.

• • •

Irving D. Wolfe, '68, Owings Mills, Md., has become a Diplomat of the American Board of Dermatology. In the past year, he has published an article in *Cutis* entitled, "Chronic Lymphocytic Leukemia Complicated by Bullous Impetigo." An article entitled, "Cutaneous Protothecosis in an Immunosuppressed Host" will shortly appear in the *Archives of Dermatology.* Dr. Wolfe is in private practice in Owings Mills and is in a part-time capacity as Head of the Division of Dermatology at Loch Raven Veterans Administration Hospital.

• • •

Frank Zorick, '67, Bangor, Maine, spent two years in the U.S.A.F. at Minot AFB, North Dakota as Chief of the Mental Health Clinic, 1971-73. He later moved to Maine and was appointed Director of the In-patient Services for the Comprehensive Mental Health Center for Eastern Maine in Bangor, 1973-74. Dr. Zorick was board certified in 1973 in Psychiatry by the American Board of Psychiatry and Neurology. In August of 1974, he became Director of Psychiatric OPD for Eastern Maine Medical Center and he is also presently a Psychiatric Consultant for the Program on Aging of the Bangor Mental Health Institute.

• • •

William F. Bruther, '66, Annapolis, Md., became a Diplomat of the American Board of Ophthalmology in October, 1975. Dr. Bruther is currently in private practice of Ophthalmology in Annapolis and is associated with Dr. Robert B. Welch. He is also a Clinical Instructor in Ophthalmology at the University of Maryland School of Medicine.

• • •

William S. Byers, '64, Galveston, Texas, announced the birth of their first child, William Anthony Byers II, on January 26, 1976. Dr. Byers is engaged in the private practice of Cardiology, is Director of the Cardiac Catheterization Laboratory at the Galveston County Memorial Hospital, and, in October, 1975, was certified as a Diplomate in the Subspecialty of Cardiovascular Disease by the American Board of Internal Medicine.

• • •

B. Robert Giangrandi, '63, Ellicott City, Maryland, obstetrician-gynecologist, has been elected president of the medical staff at St. Agnes Hospital. Dr. Giangrandi replaces Elie K. Fraiji, M.D. whose term expired December 31, 1975. A native of Baltimore, Dr. Giangrandi is a graduate of Loyola High School, Loyola College and the University of Maryland School of Medicine. He conducted his post-graduate medical education at St. Agnes Hospital, serving one year of internship and three years of obstetrics and gynecology residency. His last year was served as executive chief resident. Dr. Giangrandi served six years with the Maryland Air National Guard's 136th Evacuation Hospital in Baltimore. Since 1968 when he completed his residency training, Dr. Giangrandi has been in private practice. Dr. Giangrandi is a Diplomate of the American College of Obstetrics and Gynecology and a member of the Maryland Obstetrical and Gynecological Society. He and his wife Judith reside in Ellicott City with their four children.

• • •

Gerald A. Hofkin, '61, Baltimore, Md., is in the private practice of Gastroenterology. In addition, Dr. Hofkin serves as Chief of Gastroenterology at Franklin Square Hospital and Director of the GI Diagnostic Laboratory at Sinai Hospital. Dr. Hofkin is board certified in Internal Medicine and

Gastroenterology. He is a member of the American College of Gastroenterology, the American Gastroenterological Association and the American College of Physicians. He was recently appointed Assistant Professor of Medicine at the University of Maryland School of Medicine.

• • •

Robert A. Fink, '61, Berkeley, Cal., has been elected a Fellow of the American College of Surgeons at the 61st Clinical Congress of the College in San Francisco. Dr. Fink is engaged in the practice of neurological surgery in Berkeley, California, and is a member of the faculty of the University of California School of Medicine in San Francisco.

• • •

Morton E. Smith, '60, St. Louis, Mo., received The 1976 Founder's Day Faculty Award of Washington University. This award is given to five members of the faculty of the University for outstanding teaching. Dr. Smith is Professor of Ophthalmology and Pathology at the Washington University Medical School in St. Louis.

• • •

Richard Belgrad, '56, Richmond, Va., was appointed Associate Professor of Radiation Therapy at the Medical College of Virginia in July, 1975. Dr. Belgrad was formerly associated with the University of Rochester Medical Center, Rochester, N.Y.; and spent a year in Israel as Visiting Radiotherapist at the Chaim Sheba Medical Center, Tel Hashomer. He is board certified in Radiology and recently earned additional certification in Radiation Therapy.

• • •

Joseph Bove, '53, New Haven, Conn., Professor of Laboratory Medicine at Yale University, has been appointed to the Panel on Review of Blood and Blood Derivatives of the Food and Drug Administration. Dr. Bove, along with six other experts in the field of blood transfusion, will serve for three years in an advisory capacity to the Bureau of Biologics reviewing the safety, effectiveness, and labeling of all blood and blood products. In addition, the panel will act as an ad hoc advisory group to the Bureau of Biologics and to the Commissioner of Food and Drugs.

• • •

Hugh V. Firor, '53, Tucson, Arizona, Director of Pediatric Surgical Services of Cook County Hospital and the University of Illinois Hospital and Associate Professor of Surgery and Pediatrics at The Abraham Lincoln School of Medicine of the University of Illinois, has resigned to enter private practice in Tucson, Arizona in association with Dr. C. Peter Crowe of Tucson. Dr. Firor who has been in the above position for five years was certified in 1975 by the American Board of Surgery with the newly created "Certificate of Special Competence in Pediatric Surgery" following the first examination ever given in this sub specialty.

• • •

J. W. McFadden, '51, Hartville, Ohio, is a Diplomate of American Board of Family Practice. After 20 years in practice and 2 years as Vice President of Medical Affairs at Aultman Hospital, he accepted the position of Director, Family Practice Residency Training Program for Aultman Hospital, Canton, Ohio. The Family Practice Center is located in Hartville, Ohio and is a rural unit. This is a site where Dr. McFadden practiced in partnership previously. Two full time Co-Directors are working in the program also. The program accepted its first class of residents July 1, 1975.

• • •

Paul E. Frye, '46, Akron, Ohio, is presently the Chief of Anesthesia at Akron General Medical Center. Following his internship at Baroness Erlanger Hospital in Chattanooga, Tennessee, Dr. Frye entered general practice in Lonaconing, Maryland. His anesthesia residency was served at Ohio Valley General Hospital in Wheeling West Virginia, and he has been in private practice of anesthesia since 1954. He has been active in the Ohio Society of Anesthesiologists serving as President-elect, a District Director and has been a member of many committees. Dr. Frye is not only the father of three children, but also the grandfather of three. His hobbies are collecting antique light fixtures and working in the arts and crafts, such as painting, candle making, plastics, etc.

• • •

Leonard L. Heimoff, '39, New York, N.Y., has been appointed Clinical Associate Professor of Public Health, Cornell University Medical College. Dr. Heimoff was also elected Chairman of the Committee on Public Health of The New York Academy of Medicine in January, 1976.

• • •

Aaron Feder, '38, Jackson Heights, N.Y., has been named Consultant to the National Institutes of Health, Bethesda, Maryland. Dr. Feder is Clinical Professor of Medicine at Cornell University.

• • •

Samuel Jackson, '37, Valley Stream, N.Y., was appointed Assistant Professor of Clinical Family Medicine at the School of Medicine, State University of New York at Stony Brook, Stony Brook, N.Y. in October, 1975.

UNIVERSITY OF MARYLAND BICENTENNIAL PEWTER PLATE
IN RECOGNITION OF AMERICA'S TWO HUNDREDTH ANNIVERSARY

The University of Maryland School of Medicine and the Medical Alumni Association have commissioned the Medallic Art Company to make five hundred (500) pewter plates as shown in the illustration. These plates, measuring 5½ inches in diameter, will highlight *Davidge Hall* and have been prepared as a part of America's Bicentennial Celebration.

The *Davidge Hall* Restoration Committee of the Medical Alumni Association is sponsoring a solicitation to alumni, faculty members and former house officers, as well as friends. The subscription price is $100.00 each, which is expected to realize a significant profit for purposes of the restoration. These are collectors' items and the major portion of the contribution is tax deductible (precise information will accompany the plate). The committee enthusiastically announces this subscription and needs your support.

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FACULTY NEWS

**APPOINTMENTS,
PROMOTIONS, AND RESIGNATIONS**

Stanley L. Blum, M.D., Instructor — SURGERY (appt. eff. 11-1-75)

Stuart Winakur, M.D., Instructor — SURGERY (appt. eff. 11-1-75)

Sue A. Hudson, Ph.D., Research Associate — PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS (appt. eff. 1-5-76)

Regina L. Cicci, M.A., Clinical Assistant Professor — PEDIATRICS (prom. eff. 9-1-75)

Maria Gumbinas, M.D., Assistant Professor — NEUROLOGY (appt. eff. 10-1-75)

Ronald S. Pototsky, M.D., Assistant Professor — MEDICINE (appt. eff. 10-1-75)

Lourdes S. Ramirez, M.D., Assistant Professor — PEDIATRICS (appt. eff. 11-1-75)

Zoena Yannakakis, M.D., Clinical Assistant Professor — ANESTHESIOLOGY (appt. eff. 1-1-76)

Park W. Espenschade, Jr., M.D., Instructor — MEDICINE (appt. eff. 11-1-75)

Alice Garcia-Hamoy, M.D., Instructor — MEDICINE (appt. eff. 10-1-75)

Lawrence Adler, M.D., Research Associate — BIOCHEMISTRY (appt. eff. 7-1-76)

John W. Blotzer, M.D., Instructor — MEDICINE (appt. eff. 12-30-75)

James J. McPhillips, M.D., Instructor — FAMILY MEDICINE (appt. eff. 1-4-76)

Richard T. Smith, Ph.D., Professor — SOCIAL & PREVENTIVE MEDICINE (appt. eff. 9-1-75)

Andrew A. Zalewski, M.D., Associate Professor — ANATOMY (appt. eff. 9-1-75)

Robert H. Ude, Assistant Professor — PHYSICAL THERAPY resigned 12-31-75

Lois Young Beverly, M.D., Associate Professor — OPHTHALMOLOGY (appt. eff. 2-1-76)

Nathan H. Carliner, M.D., Assistant Professor — MEDICINE (appt. eff. 11-1-75)

Eric M. Fine, M.D., Clinical Assistant Professor — PEDIATRICS (prom. eff. 1-1-76)

Helen Rosalie Kohler, Ph.D., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE (appt. eff. 9-1-75)

Robert P. Padousis, D.D.S., Clinical Assistant Professor — PEDIATRICS (prom. eff. 1-1-76)

Stanley Rodbell, M.S.W., J.D., Assistant Professor — PSYCHIATRY (prom. eff. 7-1-76)

Harold J. Wain, Ph.D., Clinical Assistant Professor — PSYCHIATRY (appt. eff. 11-1-75)

Robert E. Cranley, M.D., Associate Professor — SURGERY (appt. eff. 10-15-75)

Chik-Kwun Tang, M.D., Assistant Professor — PATHOLOGY (appt. eff. 12-1-75)

Stamatios E. Polakis, Ph.D., Assistant Professor — BIOCHEMISTRY (appt. eff. 1-1-76)

Stanley D. Freedman, M.D., Assistant Professor — MEDICINE, resigned 12-31-75.

Robert H. Gilman, M.D., Assistant Professor — MEDICINE, resigned 12-31-75.

Suzan R. Fassett, B.A., Instructor — SOCIAL & PREVENTIVE MEDICINE, resigned 1-26-76.

Thomas J. Pfau, D.D.S., Instructor — PEDIATRICS, resigned 1-16-76.

Sohrab Mobarhan, M.D., Assistant Professor — MEDICINE, resigned 1-17-76.

ALUMNI NEWS REPORT

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Send To: George H. Yeager, M.D.
Editor, Alumni Bulletin
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School of Medicine
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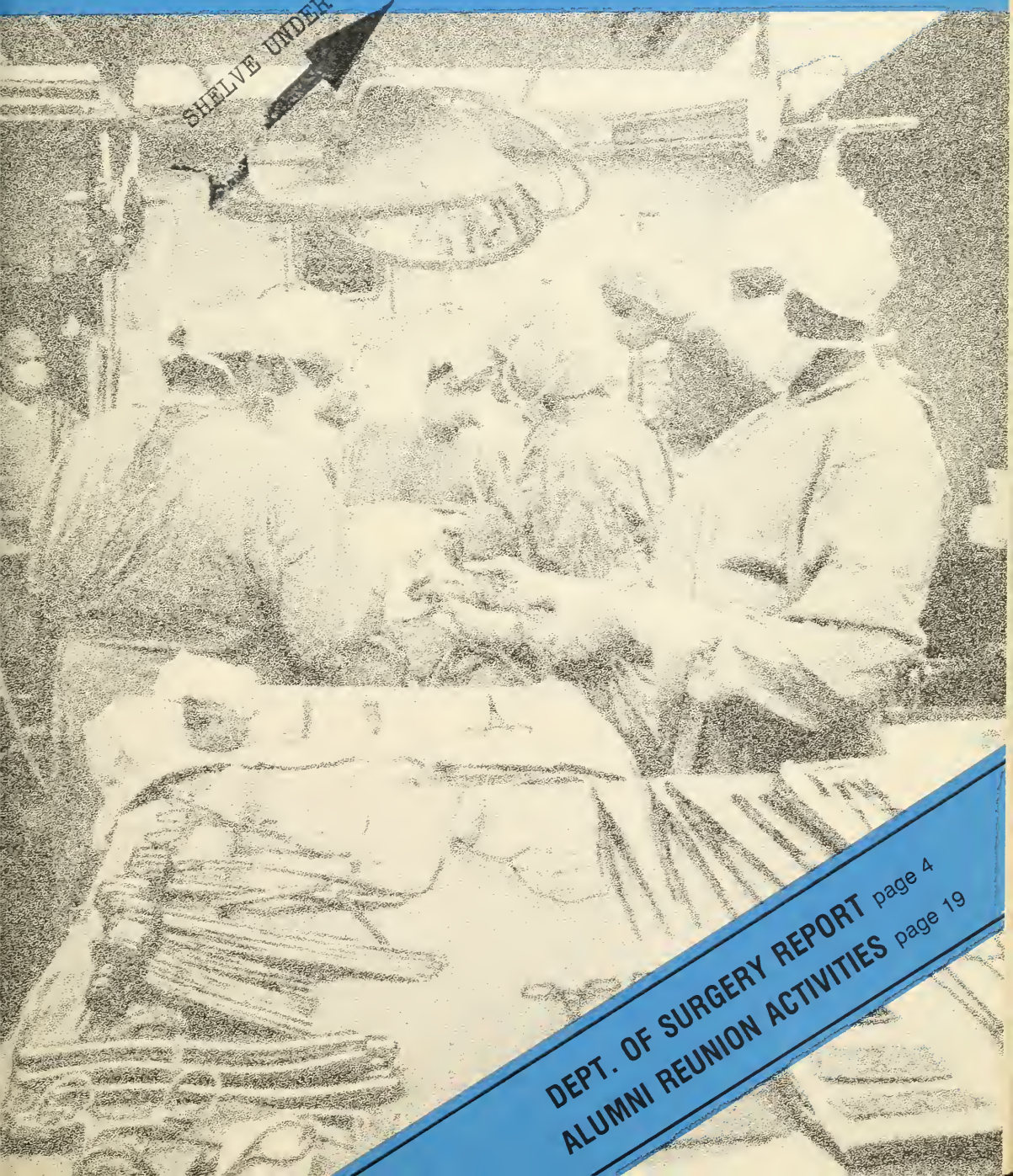
August, 1976

BULLETIN

university of maryland school of medicine



DEPT. OF SURGERY REPORT page 4
ALUMNI REUNION ACTIVITIES page 19

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George H. Yeager, M.D., Editor
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COVER PHOTO: In the operating room we see the surgeon strictly as the consummate technical artist. But both the heritage and modern profile of the surgeon in Maryland encompasses a wide spectrum of human activity. For a full report on the history and activities of the Department of Surgery, turn to page 4.
Photo by Philip Szczepanski

BULLETIN

university of maryland school of medicine

August, 1976 **Vol. 61** **No. 2**

NOTE: Mrs. Mary A. Lantz has taken maternity leave from her duties as editorial assistant, and gave birth to a baby girl, *Julie Ann*, on June 16, 1976. *Julie Ann* weighed in at 8 pounds, 9 ounces. Thomas Jackson is substituting for Mrs. Lantz while she is on leave.

ALUMNI BULLETIN REPORT:

The Department of Surgery — accelerated activity and worldwide recognition after decades of noble effort

As with other departments of the medical school, the evolution of the Department of Surgery was and is a gradual process. The department presently enjoys a prestigious reputation for high quality service; yet it has taken decades of difficult, sometimes frustrating effort to achieve its present status.

University of Maryland School of Medicine, the fifth oldest medical college in the United States, was destined over much of its 170-year history to be plagued by a lack of adequate financial support. The very existence of the School today is due to the extreme dedication and tenacity of a great number of prominent faculty members of the past. With admirable perseverance and respect for the School's tradition, succeeding members of the faculty have continued to keep the School of Medicine a reputable institution, noted for turning out excellent clinical physicians.

It should be realized that, starting with Dr. Davidge in 1807 and followed by Drs. Gibson, Pattison, Smith, and Johnson (all of whom were recorded as Professors of Surgery), none of the earliest members of the School's faculty would fit the present concept of a Surgical Professor. All these men served concomitantly in other capacities and lectured in such diverse disciplines as midwifery, anatomy, pathology and materia medica. It wasn't until the early 1880's that Dr. Louis McLane Tiffany, then Professor of Surgery, became the first physician in Baltimore to limit his practice to Surgery.

The multiple roles of Dr. Tiffany's predecessors are understandable because not much surgery was being performed. Maryland did not have a hospital until 1823. Morton/Long did not discover anesthesia until 1842-46. Prior to the use of anesthesia, the number of operations performed each year at various hospitals throughout America (e.g., Massachusetts General Hospital, Boston City Hospital, Roosevelt Hospital, New York Hospital) averaged only 20 to 40 a year. These procedures consisted mainly of amputations, vessel ligations, reductions of fractures, drainages of abscesses, and "cuttings for stones."

In the years before anesthesia, however, occasional major procedures were undertaken, some for the first time. Despite the lack of research laboratories in the early days of the University of Maryland School of Medicine, quite a few of the former Professors of Surgery proved to be sufficiently innovative and creative to perform and record some original surgical procedures. In 1816, for example, Dr. Gibson became the first in the country to perform suprapubic lithotomy. Later, he reported successfully performing Caesarian Section on the same woman twice.

In 1823 a hospital, known as the Baltimore Infirmary, was constructed at what is now the corner of Lombard and Greene. This hospital, with an original capacity of 60 beds, was built from contributions of the non-salaried faculty. It featured a semi-circular operation theater at the rear of the building, which at last made teaching from the Surgical Department a viable activity. With the advent of anesthesia, the number of operations being performed in the hospital increased tenfold.

Dr. N.R. Smith was Professor of Surgery during this period and was quick to adopt the use of ether. Dr. Smith, a prolific writer as well as lecturer and operating room surgeon, greatly elevated the reputation of the University of Maryland Surgery Department. He is best remembered for development of the internationally used "Smith splint" and the "Smith lithotome" and is recognized for the second operation on the thyroid gland in America. He also authored the definitive "Surgical Anatomy of the Arteries."

Dr. Tiffany, a former pupil of Smith, brought more acclaim and prestige to the Department of Surgery. In 1885 Tiffany is reported to have performed the first successful nephrolithotomy; in 1886, the first successful esophagotomy; in 1892, the first successful gastroenterostomy in Maryland; and in 1893, the complete excision of the Gasserian ganglion in four cases. He was elected also president of two nationally famous surgical organizations: the American Surgical Association and the Southern Surgical Association.

When Dr. Randolph Winslow was appointed to the Chair of Surgery (1902-1920), the Department was still being run entirely with the assistance of non-salaried staff. Throughout all those years and as late as 1955, teaching was done by volunteer staff. Meanwhile, greater emphasis was being placed on the teaching activity as the requirements of graduation from the School became more demanding.

Across town, the Johns Hopkins Hospital opened in 1884. With an eminent staff and generous financial support, the Hopkins began to steal the limelight with its emphasis on research and full-time structure. Despite the friendly competition, Dr. Winslow continued to add prestige to the Department of Surgery. He became a founder of the Association of American Medical Colleges and the American College of Surgeons. He served as President of the Southern Surgical Association and was a member of other national surgical organizations. He was the first surgeon in Maryland to perform pyloric resection for cancer (1885) and vaginal hysterectomy (1888), and he was the first to successfully operate on gunshot wounds of the intestine

As the School of Medicine continued its quest for new medical knowledge and improved applications, it began to struggle with a physical plant that seemed more inadequate with each passing year. As buildings grew old and laboratories became ill-equipped, the hospital gradually found itself outdated. Research, except of the clinical type, was practically non-existent, although the faculty remained loyal and instruction continued despite obvious handicaps. In contrast, the Hopkins star continued to rise.

In 1922 there was a move made by prominent figures in high places to close down the University of Maryland School of Medicine. In response, dedicated members of the Surgical and Medical Faculty appeared time and again before the Legislature to plead the cause of a University medical school. Finally, after much debate, the motion to close the School was defeated and a new surge of interest in the development and future of the School arose. The result of this vote of confidence was a greatly increased budget allocation, a new hospital at the corner of Greene and Redwood, a new nurses' home, and a windfall in the form of the Bressler Fund.

The new era of growth and development was actually ushered in when Dr. Arthur Shipley was appointed Professor of Surgery (1920-1948). Some of the surgical sub-specialties were finally recognized, and the following appointments were made: Dr. Edward Looper, Otolaryngology, 1922; Dr. William H. Toulson, Urology, 1930; Dr. Charles Bagley, Neurosurgery, 1930; and Dr. Allen Voshell, Orthopaedics, 1931. All these men were very active in their fields and limited most of their practice to the University of Maryland Hospital. None of them received a salary from the University.

In 1946, Dr. Shipley appointed Dr. Fred Dye as full-time Division Head of Anesthesiology. In 1952, Anesthesiology became a separate department and was headed by Dr. Robert Dodd. In 1951 Dr. R. Adams Cowley was appointed Head of the Division of Thoracic Surgery.

In 1955 Dr. Robert Buxton was appointed as the first full-time Professor of Surgery at the University. Full-time appointments in all departments took place rapidly and included division heads.

The budget for the Department of Surgery rose from $60,000 in 1955 to $1,800,000 in 1970 and to $2,500,000 in 1975. Teaching, surgical, and administrative duties were gradually taken over by the full-time staff. The volunteers and part-time staff who formerly played such a large role in teaching slowly migrated to other hospitals. Dr. Cowley was appointed Director of the famous Shock Trauma Unit in 1960. In 1970 Dr. Joseph McLaughlin was appointed Head of the Division of Thoracic-cardiovascular Surgery.

In 1971 Dr. George Robert Mason was appointed Professor and Chairman of the Department of Surgery. General Surgery is now divided into five sections: Gastroenterology, Oncology, Vascular Surgery, Transplant Surgery, and Pediatric Surgery. These five sections are under the supervision of nine attending physicians and ten house officers. A small number of junior students, varying from three to five, rotates on these services. In addition, the Department of Surgery maintains affiliations with three local hospitals—Maryland General Hospital, Mercy Hospital, and Baltimore City Hospitals—where students also rotate. Divisions of Otolaryngology, Orthopaedics, Neurosurgery, Urology, Thoracic Surgery, and Cardiovascular Surgery all have their separate areas of operation. There is a total of twenty-one attending physicians at the University covering Surgery and its divisions, and a total of 78 house officers in the program. Of a junior class of 170, about one half rotate through the University program.

Approximately every 25 to 35 years since 1823, the University has constructed a large addition to the existing hospital or built a new hospital. In 1971, the new North Hospital addition opened to increase the maximum bed capacity of the institution to 924. All the new space, including beds, recovery rooms, I.C.U.'s, operation rooms, examination rooms, office space, outpatient facilities, and treatment areas, was enthusiastically received. However, at this date, the beds for surgical patients seem to fill as rapidly as they are opened and admission of both emergency and elective patients still poses a problem.

During the tenure of Dr. Mason the tempo of work in the animal laboratory has accelerated with a full-time director providing supervision and more space and equipment allocated to the lab. Several months elective study in the animal laboratory are available for surgical house officers, and, commencing 1976, a full year fellowship will be an integral part of the residency at the third year level. In the hospital, facilities for esophogeal motility and detailed vascular and endoscopic studies are finding more and more use. The ward services are constantly busy and offer a wide variety of surgery to the residents in training in their rotations. In addition, house officers in surgery in the general hospital rotate through the Maryland Institute for Emergency Medicine and receive training in the care of the acutely traumatized patient. They also rotate at the affiliated hospitals.

With the opening of the Baltimore Cancer Research Center on the ninth floor of the Hospital in 1974, the surgical staff now has access to the expertise of specialists in the latest advances in chemotherapy in the treatment of cancer.

The objectives of the Department remain essentially the same as those of its counterpart of yesteryear: quality patient service, the teaching of students, the training of surgeons in the various specialties, participation in community hospital education programs, and contribution to the ever-expanding knowledge of surgery. Increased support from the State of Maryland over the years, together with a continuation of the spirit of dedication of the Maryland surgeons of bygone years, has enabled the Department to now be ranked among the most qualified in the world. The Department of Surgery is in an excellent position to look ahead to the further development of its services and facilities. And yet it will not take for granted the historical struggles against hardship of its predecessors and will always commemorate the noble efforts of its surgeons of the past.

ALUMNI BULLETIN REPORT

Division of General Surgery Section of Oncology

W. Gregory Bruce, M.D.
E. George Elias, M.D., Ph.D.

This section is very active in the management of patients with all types of solid tumors. Surgical approaches and also chemotherapeutic management and immunotherapy are utilized. More recently, emphasis has been placed on immuno assays to monitor the status of cancer patients, to predict the serologic response and to support the clinical management of the patient.

The section has been actively engaged in work and collaboration with the Baltimore Cancer Research Center in teaching and clinical research. Surgical oncology is responsible for staging of lymphomas and surgical management of patients admitted to BCRC. It is hoped that in the near future more clinical study protocols will be activated by the two groups.

New surgical approaches are being advocated by this section, especially in the area of head and neck, where the delto-pectoral flap is being utilized extensively in reconstructing major surgical defects. The Otolaryngology division is cooperating extremely well with the section and plans further collaboration

to initiate adjuvant radiotherapy post-operatively for patients with poor prognosis.

It is also planned that more infusions and perfusions of chemotherapeutics will be administered when the surgical oncology floor is activated. The nurses on this floor will be educated and well trained in the management of chemotherapy techniques. This team will be further exposed to methods of vaccination in chemotherapeutic patients. A clinical immunology laboratory is being set up to monitor the immune response in cancer patients and will be located on the same floor as the surgical oncology unit.

The section has joined the National Surgical Adjuvant Breast Project and Cancer-Leukemia Group B so that the patients will receive the utmost in care including new chemotherapeutic agents. These affiliations will provide excellent teaching material for the medical students and the residents.

It should be emphasized that cancer research goes hand-in-hand with cancer education and reflects a tremendous value in patient care. The collaboration of the surgeon, internist, radiotherapist and pathologist is to be emphasized in all future plans to encourage new multidisciplinary approaches in cancer control.

Finally, the section of surgical oncology is attempting to set up a cancer control network not only for patient referral but also to make itself available to all physicians in the state of Maryland for consultation.

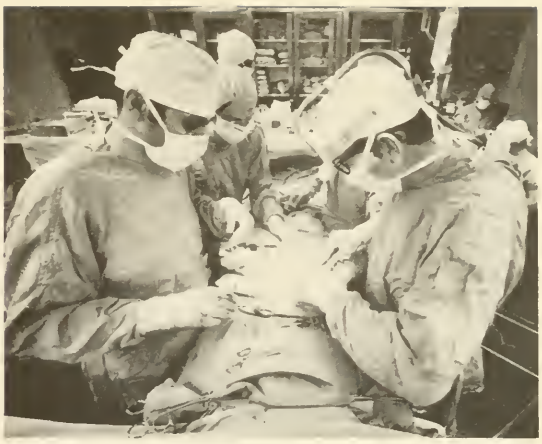
Section of Transplant and Vascular Surgery

Fuad J. Dagher, M.D.
Graham Fallon, M.D.
René L. Gelber, M.D.
Said Karmi, M.D. (Urology)

Because of the need for high quality patient care in the peripheral vascular and kidney transplant fields, and in response to the need for specialized training of young general surgeons interested in therapy of patients with peripheral arterial and venous disease as well as patients with end-stage kidney disease, a special section in vascular and transplant surgery has been established and incorporated as part of the division of general surgery. Residents, on the senior as well as junior levels, rotate through this service during their training program.

Vascular Surgery

This program was started officially three years ago. It is designed to provide the qualified surgical resident with a broad exposure in the field of peripheral vascular surgery. The educational experience here



stresses surgical judgment, the acquisition of technical skills, and a thorough understanding of circulatory hemodynamics as they relate to vascular pathology.

Weekly multidisciplined conferences in the areas of vascular surgery, radiology, and rehabilitation of the amputee are attended regularly and are closely integrated with vascular and diabetic clinics. A weekly vascular clinic is held where patients with peripheral vascular pathology are referred for care and management.

A new peripheral blood flow laboratory has been established. This lab provides the latest in diagnostic techniques and instrumentation and, with the assistance of a full-time trained technician, has added another dimension of preoperative evaluation and postoperative management and care of patients with peripheral vascular problems. Studies incorporating the use of the Doppler ultrasound, treadmill stress, and plethysmography are becoming routine. The use of radioisotopes—and specifically Xenon washout studies—for blood flow evaluation is also available.

Applied clinical investigations are performed in the peripheral vascular lab and the Bressler Research Institute in the areas of intestinal ischemia, tissue oxygenation, the neurotropic ulcer of the diabetic, and blood flow measurements following arterial reconstructive procedures.

Transplantation Surgery

At the University of Maryland Hospital the first kidney transplantation was performed by Dr. Thomas Flotte in 1968. However, the transplant service was officially recognized only three years ago.

This program is designed to provide another therapeutic modality in addition to chronic hemodialysis to patients with end-stage kidney disease. In 1973-1974, 31 kidney transplants were performed and, despite the reduction in surgical staff to a single transplant surgeon, 20 kidney transplants were performed in 1974-1975. However, with the addition of a new staff on the transplant service, the

number of kidney transplant operations is expected to approximate 35 transplants during this fiscal year.

The transplant program serves not only the state of Maryland but part of the District of Columbia, Delaware, and southern Pennsylvania.

In providing this service, we closely collaborate with the division of nephrology at University of Maryland. Nephrology fellows from the University Hospital, as well as from Maryland General Hospital, are part of the transplant team and take active part in the management of the transplant patient. Surgical residents on the service assume primary responsibility for the every day care of these patients, thus acquiring experience in transplant immunology, immunosuppression, and pre- and postoperative care of patients with end-stage kidney disease receiving renal allografts.

The transplant service at University of Maryland Hospital is a member of the Southeastern Organ Procurement Foundation, an Organ Sharing Foundation. Kidneys harvested by our team (44 kidneys harvested in 1974-1975) are usually shared by other Baltimore transplant institutions as well as other members of the above Foundation.

Significant and major contributions have been made by the transplant service, including a new method of predicting and detecting early acute rejection of renal allograft using autologous radioactive fibrinogen (a method first used in this nation by the University of Maryland). Another first was the development of a new vascular access for hemodialysis in the upper arm using the patient's own basilic vein and brachial artery, a procedure which has gained great popularity.

Plans are under way for close collaboration with the section of surgical oncology in investigative work involving tumor and transplant immunobiology.

Section of Gastrointestinal Surgery

Theodore Eisenstat, M.D.
Harry C. Hull, M.D.
G. Robert Mason, M.D.

The section of gastrointestinal surgery is primarily oriented toward major diseases of the upper gastrointestinal tract. Because many of the problems of gastrointestinal surgery are readily handled by surgeons in community hospitals, interests in the gastrointestinal surgery section have been oriented toward those problems which might represent complications of usual care, or unusual problems which are not readily diagnosed by the customary methods. To this end, the staff has developed in its own areas of interest the use of special diagnostic devices such as esophageal motility and manometric testing as well as the use of fiberoptic endoscopic devices.

Esophageal manometric examination is useful for disorders of motility as well as questionable cases of gastric reflux and hiatus hernia. Frequently the standard methods of investigation, which include barium contrast radiographs and esophagoscopy, fail to delineate functional disturbances of the neuromuscular portion of the esophagus. Similarly, problems of acid reflux are not always readily apparent with barium solutions or at endoscopy. The presence of pressure differentials created by muscular activity of the esophagus related to its presence in the thorax or abdomen can relatively easily be appreciated on tracings through pressure changes in perfused catheters placed in the esophagus and stomach. Similarly, the use of acid solutions for clearance studies in the esophagus, or as a measurement of reflux of an acid solution from the stomach, can render the diagnosis of reflux esophagitis more secure.

During the last decade the rapid development of numerous fiberoptic devices has made it possible to penetrate throughout the gastrointestinal tract even to recesses of the pancreas and biliary tree through an oral route. Dr. Theodore Eisenstat has been quite successful in acquiring a series of endoscopic retrograde pancreatocholangiograms for the elucidation of difficult problems of pancreatic pathology and biliary tract pathology. With this technique it is often possible to ascertain the presence of biliary tract lithiasis versus malignancy prior to operation, thus saving many hours of frustrating work attempting to obtain pancreatic biopsies or intra-operative cholangiography. Similarly the nature and progression of pancreatic disease related to alcoholism or other more obscure etiologies has, to this point, been poorly appreciated. The possibility of following such patients with chronic pancreatitis, pseudocysts, etc., now has been made possible by the use of fiberoptic retrograde pancreatography. At the other end of the gastrointestinal tract, the use of the fiberoptic colonoscope has made it possible to visualize the entire length of the colon as well as portions of the terminal ileum. In the past, it has been necessary to resort to an operative laparotomy approach for various lesions and polyps of the gastrointestinal tract. By the use of fiberoptic colonoscopy it is now possible to either remove these lesions or biopsy them and ascertain the true need for such operative procedures prior to the laparotomy itself.

The gastrointestinal surgery section has been most fortunate in achieving cooperation with the gastrointestinal division of the Department of Medicine and has instituted joint rounds on a regular basis and a joint conference with gastroenterology and a second conference with gastroenterology and radiology.

Division of Neurosurgery

Thomas B. Ducker, M.D.
Michael Salcman, M.D.
Walker Robinson, M.D.

Neurological surgery at the University of Maryland School of Medicine is a complex multi-structured program developed over thirty-five years ago, and is credited with producing over thirty Board-certified graduates in active practice at this time. This fact makes it one of the older training programs in North America, located in the fifth oldest medical school in the United States of America. The founder of the division and first professor of neurological surgery at University of Maryland was Dr. Charles Bagley, Jr. and from the late 1930's until 1952 he guided the program. Dr. James G. Arnold, Jr. was his successor and was responsible for the tremendous growth of the service to its current size, with major teaching programs, a faculty of nearly twenty physicians, a service in-patient load of up to sixty patients, and meaningful basic research. In 1975, Dr. Thomas B. Ducker became the Professor and Head of the division and further expanded the specialty with micro-neurosurgery, computer clinical research, and clinical neurophysiologic conduction techniques, and has related such expertise to the University's academic programs. The entire faculty of the Division continues with the strong participation of both practicing and academic surgeons freely interchanging in the spirit of total growth of the specialty.

A strong neurological surgery program is most commonly a function of a strong faculty. Members of the University of Maryland neurosurgery faculty boast membership in many learned societies of medicine and neuroscience, such as the American Medical Association, the American College of Surgeons, the Medical and Chirurgical Faculty of Maryland, the American Association of Neurological Surgeons, the Society of Neurological Surgeons, Congress of Neurological Surgeons, Neurosurgical Society of America, Southern Neurosurgical Society, Society of British Neurological Surgeons, Maryland Neurosurgical Society, New England Neurosurgical Society, Association for Research in Nervous and Mental Disease, Society of Neuroscience, American Association for Surgery in Trauma, and the International Association for the Study of Pain. Not only do the physicians hold membership in such societies, but they also have given generously of their time to hold positions, and our faculty includes a member of the Board of Directors of the American Association of Neurological Surgeons, two past Presidents of the Congress of Neurological Surgeons, a past President of the Neurosurgical Society of America, a past President of the Southern Neurosurgical Society, several trustees of the Foundation of the International Education of Neurological Surgery, a representative to Care-Medico Representatives to Project Hope, several members of the executive committee of the World Federation of Neurosurgical Societies, and the President of the Maryland Neurosurgical Society.

The entire faculty participates in the teaching of medical students and the training of neurosurgical residents, using didactic teaching, clinical teaching, conferences, journal clubs, and man-to-man teaching techniques. The faculty operates in two hospital settings and this offers a splendid basis for the student and resident trainee to function in both the "ivory tower" and a "community hospital", and to see both sides of the practice of medicine.

Teaching facilities begin in the relationship of neurosurgery within the University of Maryland School of Medicine. The whole Medical School with all its departments is available for intercommunications with the academic side of medicine. The preclinical teaching facilities which are used by the neurosurgical service to the greatest extent are those of anatomy, wherein gross anatomy is available for dissections of specimens to further understand surgical anatomy. Special neuroanatomy instruction is available and given not only to the students but also the resident physicians as part of the routine early residency training. Our own neurophysiologic and neurosurgical research laboratories are available for student and resident training, depending on the desires and needs of the person. For example, during his residency training, Dr. Crosby spent several years in the research laboratories because of his interest in investigative work. His operations on smaller primates and other experimental animals allowed him to develop special techniques and interests which ultimately led to the specialty of pediatric neurosurgery. Another example is that of the late Dr. George Smith, who spent several years in the laboratory, then was an assistant professor at Johns Hopkins University, and at the time of his death was professor of neurological surgery at the University of Georgia in Augusta.

Teaching programs are developed for all levels of medical education. In the medical student's first year, part of a combined program with medical neurology is given in which the basic neurologic physical examination is demonstrated. In either the first or second years, medical students can elect an intensive seminar in basic and clinical neurophysiology. In the second year, the student examines patients and performance is reviewed by faculty members. In the third year, each student spends three weeks on a combined medical and surgical neurology rotation. In his or her fourth and last year, the medical student may function as an extern on the service and take part in operations, etc. After graduation, interns may rotate on the service for

one month. Thereafter a five year residency program leads to Board qualification as a specialist. Each physician who enters the program progresses through a junior residency rotation, programs and research in clinical studies, special neuropathology courses, a neurology course in England, and a position as senior resident on neurosurgery in pediatrics at Mercy Hospital and in the Maryland Institute of Emergency Medicine. In his final eight months, he is a chief resident on the adult floor at the University of Maryland Hospital.

For the practicing physician, there are two kinds of teaching programs available. One is for the practicing generalist, the family physician, the internist, etc., wherein the faculty gives continuing education talks on topics such as cerebral vascular disease, tumors, and trauma. The second is designed for the practicing neurosurgeon and consists of special weekly conferences, literature reviews, and special courses. The library facilities naturally contribute to the educational process. The staff library on the neurosurgery floor in the University Hospital is excellent and current. The University of Maryland School of Medicine Library lies across the street and houses a majority of neuroscience journals. The historic section of the medical school library goes back to the early 1800's. The Welch Medical Library is available within 15 minutes travel and supplements the University of Maryland Medical School Library as does the Medical and Chirurgical Faculty Library which again is 15 minutes from the hospital. These latter three libraries have 80 percent of the English literature of neuroscience as well as many foreign journals. Within 40 minutes, one can visit the National Library of Medicine on the outskirts of Washington and have available the most complete facility in the United States.

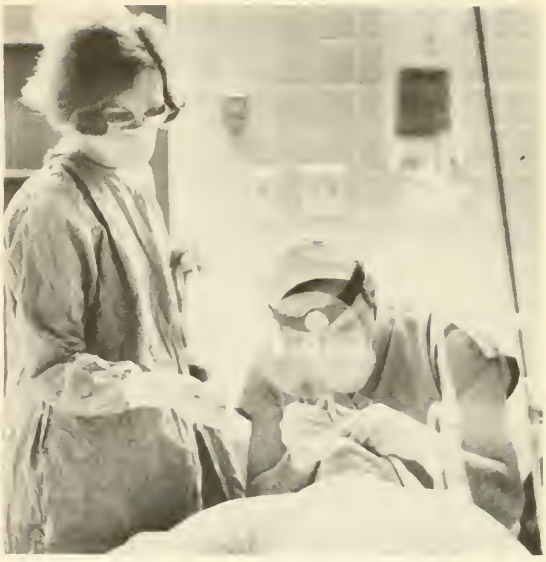
Service and medical care are of great importance to this division. Special clinical facilities that aid in the care of the patients include neuroradiology, neuroanesthesiology, brain scanning by radioisotope techniques and computerized axial tomography (CAT or EMI), electroencephalography, electrophysiological evoked potential, to name but a few. Patient services are available for the student and resident training programs and are located on the neurosurgical floor on the 12th floor of the new hospital. This unit incorporates special classrooms, conference rooms, and offices for the professional staff, resident trainees, and neurophysiologists. The students have their own special study with videotapes. The residents have their office and study room. The neurosurgical beds are available in one area of the hospital so that the patient service is concentrated for better expertise and health care delivery. The neurosurgery intensive care area is a modern and up-to-date facility with computerized electrical equipment so that each patient is assured the accurate monitoring of his or her condition. On the adjacent 12th floor, the neurology service has its intensive care unit.

On the seventh floor in the University Hospital, two specialized and fully-equipped rooms are available for the neurosurgical service. In addition, in the same suite, with complete neuroanesthesia support, two neuroradiological operating rooms are equipped for detailed neuroencephalography, angiography, selective angiography, myelography, tomography, x-ray localization of catheters and x-ray localization for operative and percutaneous stereotaxic surgery. All the instrumentation for detailed stereotaxic surgery, surgery for epilepsy with EEG monitoring, microneurosurgery, and cryoneurosurgery is available. In addition, Mercy Hospital provides further expansion of the neurosurgery program wherein much of the pediatric surgery, carotid artery surgery, and certain spine surgery is performed. All operative procedures, as well as specific pulmonary-ventilatory control to aid either the central nervous system disorders or pulmonary problems in patients, are under the direction of our own neuroanesthesia staff from the Department of Anesthesia. With such expertise, diagnostic and operative procedures are more safely carried out in one area of the hospital where there is all the necessary equipment and facilities. The University of Maryland physical plant for this care is distinctly one of the finest in the country and allows ideal interplay between neuroanesthesia, neuroradiology, medical neurology, and neurosurgery.

The nursing facilities complement the neurosurgery service facilities. Over a period of years, the nursing service has been given supplementary training to produce neurosurgical nurses. This is now culminated in a National Neurosurgery Nursing Society in which members of the present nursing staff are in executive positions. The neurosurgical nursing is divided into clinical nursing, which is made up of the primary nursing care; the operating room nursing, which consists of a nursing team developed for the skilled performance of special surgical procedures; and the intensive care nursing, which consists of nurses that are familiar with the care of the comatose patient who requires computerized monitoring. As well as the patient care of neurosurgical patients, the nurses are familiar with investigative work which periodically is performed. In addition, starting in 1976, the patient services will have a "practitioner". This specialized individual will be another bridge between the physicians and the nurses, the position being that of a graduate nurse with special postgraduate training. The "practitioner" in reality will be funded by the physician's payroll and belong to the physicians' team. Such a person will be involved daily in patient review and physicians' orders so that they can be carried out readily with understanding by all.

The source of patients is by referral to either the clinical or academic neurosurgeons. This implies the routing of private neurosurgical patients from the surrounding hospitals into the University of Maryland neurosurgical service for diagnosis, treatment, and inclusion in the residency and medical school teaching formats. There is a constant flow of complex, varied, and difficult patient cases into the service. With rotation of the clinical faculty, supervision of the service is broad-based with a varied but strong background. The multiple-faculty handling of private cases gives the student and the trainee the full spectrum of clinical judgement. All cases thus form a corpus of clinical material from which groups of cases can be catalogued into special neurosurgical problems for the purpose of teaching. At the same time, the patient receives optimum personal neurosurgical care.

Research is naturally important if a specialty is to continue to grow. Currently, there are both basic and clinical studies. Firstly, in basic research, anatomic and physiologic data on the fiber distribution and sorting of sensory information up the spinal cord and through the brain are being mapped. This laboratory work is being correlated with the clinical use of computer-summated evoked potential in patients with disorders of the spinal cord. Secondly, basic anatomic and pathologic studies are in progress to devise a new way of removing deep intracerebral hematomas. At the same time, the intracranial pressure of patients with cerebral vascular accidents is being monitored in hemorrhagic infarction. If there is related increase in intracranial pressure it is appropriately treated, and the newer anatomical studies can be utilized to remove mass lesions. These latter studies are expected to be funded by the National Institutes of Health as part of the University of Maryland Stroke Center grant in neurology. Thirdly, and of great importance to the University, are studies in traumatology. In basic research, we have done head and spine trauma experiments comparing doses of hydrocortisone that influence the outcome after injury. Clinically, in the Maryland Institute of Emergency Medicine, we carry out programs in which we compare the effectiveness of various drug dosages in injured patients. Simultaneously, we are detailing a neurologic examination that can be computer-analyzed. Fourthly, we have important ties to the Baltimore Cancer Research Center, a part of the National Institutes of Health and the National Cancer Institute. Neurosurgical fellows from training programs throughout the United States can spend time in that special service and perform meaningful research. These fellows are incorporated in our teaching program, and all our malignant brain tumor patients are treated by that service. All research material in turn is detailed for the National Cooperative Study in Chemotherapy on Brain Tumors.



It is important to say a few words about the neurosurgical residency. It is basically a non-pyramid service so that an individual, once accepted for training in the residency program and if he completes his work satisfactorily, will proceed through the residency to Board eligibility when his training is complete. The residents have their own outpatient department for patients selected from those referred from other outpatient services. (The actual case load and type of cases available to the residents in the past is detailed in our annual reports within the Department.) It becomes quite obvious that a sufficient number of clinical cases passes through the residency training program so as to make it one of the most prolific programs in North America. The residency, while structured, is not so rigidly programmed that variations in training are not possible. The resident has opportunities to complete basic training at home and abroad with an opportunity to see and receive training in various neuroscience centers. At the present time, the routine neurologic training is obtained at the National Hospital at Queen Square in England. This supplements the neurological training obtained at the University. The resident has exposure to National Society meetings during his latter years. In the past, with the help of various neurosurgery faculty, residents have been placed in neurophysiological laboratories like that of the University of Wisconsin; the neuropathology laboratory at Yale University; the clinic of Dr. Norlean in Goteburg, Sweden; the Switzerland Neurosurgery clinic of Dr. Krayenduhl in Zurich; and the neuroradiology courses at the Neurologic Institute in New York City. The residents, following the completion of the training program, have continued their specialized postgraduate training in various subspecialties in neurosurgery to further develop their expertise for the total service.

The most important aspect of the Division of Neurosurgery at the University of Maryland hinges on a matter which is largely intangible, but vital—and that is the personal relationship between the hospital and the staff, the staff and the residents and the students, etc. The University's programs, because of the character and influence of Dr. Arnold, have produced a large number of neurosurgeons who remain interested in and devoted to the University Hospital and the neurosurgical service. The result is that the atmosphere of the whole Department has been one of great mutual confidence and comradeship among all members, which is probably the hallmark of this division. Student and resident teaching is enhanced with the interest and application of the attending staff. The lively neurosurgery conferences, which are known throughout the hospital are an unusual and successful mixture of clinical presentations, radiological and pathologic demonstrations, and vigorous participations by and between the attending and resident staffs. This same atmosphere prevails in the clinical care and diagnostic and surgical procedures performed with the patient. Another manifestation of the spirit in our Division is the firmly established but informally defined network of referrals to the neurosurgery service. The University of Maryland neurosurgeons deal with referring physicians from all over the state of Maryland and beyond, and while appropriate primary care is given in the community hospitals, more complicated and instructive problems are routinely transferred and referred to the University Hospital for the benefit of the patient and the instruction of the resident staff. The Maryland Institute of Emergency Medicine (Shock Trauma Unit) and the Baltimore Cancer Research Center, both of which are within the University of Maryland and both of which work vigorously with the academic programs, contribute most significantly to this atmosphere. This complete network has enabled the University to provide the clinical setting that far exceeds the requirements established by accreditation boards for the maintenance of excelllent programs in Neurosurgery. In addition, it has allowed for health care delivery in surgical neuroscience and clinical neuroscience to function more effectively in areas which are of primary interest and concern to the specialty of neurosurgery.

Division of Orthopaedic Surgery

Roger H. Michael, M.D.
Charles C. Edwards, M.D.
Homer C. House, M.D.

The Orthopaedic Program at the University of Maryland is an approved four year program offering a well rounded education in orthopaedic surgery achieved through cooperation with The James Lawrence Kernan Hospital and St. Agnes Hospital. The program is based in the University of Maryland Hospital which serves a populace with multiple orthopaedic problems and is also a state referral center for unusual orthopaedic cases. The Division of Orthopaedic Surgery works in conjunction with the Baltimore Cancer Research Center, which is also located in the University Hospital and serves as a regional center for the treatment of diverse cancer problems, many of which involve the musculoskeletal system.

The Orthopaedic Residency Program is usually preceded by one or two years of training in General Surgery and the entire training period normally encompasses a period of five years including a year of general surgery. Following the year of general surgery, the training program is roughly divided as follows:

1) Basic fundamentals or orthopaedics including trauma and reconstructive orthopaedics at the University of Maryland.
2) A year of pediatric orthopaedics at Kernan Hospital.
3) A year of general orthopaedics, both adult and pediatric, in a non-university setting.
4) A year of chief residency at the University of Maryland Hospital which includes rotations on specialty services.

All residents participate in a regularly scheduled conference program at the University Hospital. This includes a weekly basic science course, clinical conference, and featured speaker. In addition, there are weekly preoperative conferences and formal ward rounds. A full schedule of conferences is also available at Kernan Hospital. The residents attend a monthly Journal Club meeting to review articles in appropriate orthopaedic journals and are given an opportunity to give didactic lectures to nursing, medical and physical therapy students. Outpatient clinics are held several times a week for both adult and pediatric problems. These clinics are supervised by Board-certified attending physicians. In addition, special clinics in myelomeningocele, scoliosis, cerebral palsy, and rehabilitation medicine are held on a regularly scheduled basis at Kernan Hospital. All residents are sent to the prosthetics and orthotics course at New York University and are given the opportunity to attend additional appropriate regional and national meetings. In July 1974, Dr. Homer House was appointed Assistant Professor of Orthopaedic Surgery and Director of the Hand Service. This program has become a very busy and popular service where cases are treated both in the Emergency Room and Hand Clinic. The residents participate in the care

of a wide variety of problems ranging from acute trauma to long term reconstructive hand surgery and have increasing responsibility in the care of these patients.

An annual course in bone pathology is offered in conjunction with the Johns Hopkins University and is taught by Drs. Howard Dorfman and Robert Cranley. In addition, each resident has an opportunity to elect a three month basic science rotation in orthopaedic pathology with Dr. Dorfman, a widely known expert in bone pathology.

In September 1975, Dr. Charles Edwards, a former Maryland graduate and recent graduate of the Yale orthopaedic program was appointed Assistant Professor with the primary responsibility of developing an orthopaedic research laboratory. At the present time the research laboratory is in full function with the capable assistance of Thomas Hill, a laboratory scientist. Residents at all levels are encouraged to undertake research projects. Research projects in progress include basic physiologic research in the factors affecting bone growth and healing, the use of reconstituted bovine collagen as a grafting material, and the effect of various factors on the metabolism, ultra-structure, and the repair of articular cartilage. Dr. Edwards is particularly interested in the effect of hyperbaric oxygen on the growth of bone and its effect in the treatment of osteomyelitis.

The Division of Orthopaedic Surgery in conjunction with the Program of Continuing Medical Education at the University of Maryland has sponsored "Orthopaedic Day" for the past two years. This program has been successful in reaching out into the community to those people who are caring for patients with musculoskeletal trauma. Guest speakers in the past two years have included Dr. Edward Riseborough of Harvard, Dr. Robert Hensinger of DuPont Institute, and a host of well known Baltimore orthopaedists.

Dr. Michael, the Acting Chairman, has been particularly interested in Medical Education and has published a manual of orthopaedic surgery specifically designed for the students at the University of Maryland. During the past two years an integrated program has been developed for the junior medical students, including the use of the orthopaedic manual supplemented by sound/slide programs and lectures from the full-time staff.

In summary, the University of Maryland Orthopaedic Program offers a flexible residency with clinical variety and increasing responsibility, meeting all the requisites for the American Board of Orthopaedic Surgery. Intellectual curiosity is encouraged, as the goal of this program is to develop a sound and competent orthopaedist.

Division of Otolaryngology

Cyrus Blanchard, M.D.
Hubert Leveque, M.D.
W. Charles Schaeffer, M.D.

Otolaryngology became a specialty of the Department of Surgery under the direction of Dr. Edward Looper. Dr. Looper possessed an inquiring mind and great skill as a physician. He published on outstanding original concepts in laryngeal surgery which are still cited in the current bibliographies of many papers dealing with laryngeal and tracheal reconstruction. Following Dr. Looper's death in the early 50's, Dr. Thomas O'Rourke took over the stewardship of the program. Dr. O'Rourke attracted a number of young physicians to the program and enriched a fine educational program.

As in many departments and divisions of the medical school where full-time program directors have followed, the emphasis on a major hospital-based service and teaching program has evolved.

The generous support of the Department of Surgery, the Medical School, and the University have developed a Division of Otolaryngology which has physical facilities and manpower represented in physicians, staff, speech and hearing personnel, and research personnel that are equivalent to most programs in the United States. It is gratifying that we have been able to see the Division develop from a fundamentally clinical program to a participant in research in various areas with some thirty or more publications by staff members over the past twenty years.

In a number of studies, the investigators pioneered in presenting reports which were the first records concerning various phenomena particularly related to electrophysiological study of brain activity in experimental and clinical situations.

The Division foresees a constant demand for well-trained otolaryngologists, which is a very important aspect of our objectives.

The second aspect is even more important these days relative to numbers—that is, the preparation of well-trained primary care physicians who can evaluate the problems related to ears, nose, and throat and appropriately consider their significance. This represents a very important part of the Department's efforts. At the present time there is a formal schedule of rotation of Family Practice trainees, primary care trainees in the Department of Medicine, and active training of the pediatric primary care physicians.

The medical student completing his training in the next few years will be encouraged undoubtedly by

Surgical Endoscopy and the Looper Clinic at the University Hospital

Figure 1: then . . .

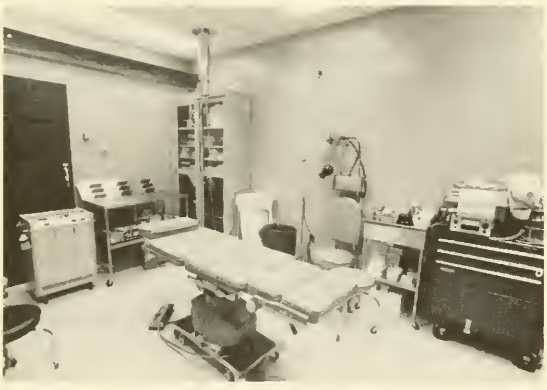


Figure 2: . . . and now.

In 1930 Doctor Edward A. Looper established the "Looper Memorial Bronchoscopic Clinic, for treatment of the diseases of the ear, nose and throat". At that time, esophagoscopy and bronchoscopy were in their infancy and this new clinic provided the University Hospital with one of the best equipped facilities in the South (see figure 1).

Since its conception, the clinic has grown in size and scope until today it represents a multidiscipline endeavor of the Divisions of General Surgery, Thoracic Surgery, and Otolaryngology.

The present facility is located in the new North Hospital building. The operating suite is equipped with the latest fiberoptic instruments and is staffed by a full time R.N. and assistant who have special training and experience in all fields of endoscopy. In addition, there is an adjacent three-bed recovery room to facilitate handling post-procedural patients and outpatients. (See figure 2).

both financial and other inducements to be a primary care physician. From recent statistics (1975 Association of the American Medical Colleges), it appears that there will be just as many candidates for specialty positions in spite of primary care trends.

The demand for an opportunity to study and become involved in the evaluation of the patient with ears, nose, throat, head, and neck disease represents an important contribution to the medical student's experience. With the department's present undergraduate schedule of Introduction to Clinical Practice in the specialities, providing each student with six hours in the Freshman year, six hours in the Sophomore year, and then 2 weeks in the Junior year, and with an elective period for those concerned with such specialities as Neurosurgery, Neurology, Pediatrics, Primary Care, and Otolaryngology in the Senior year, we plan to be busy as a teaching facility in the medical school.

The department's association with Baltimore Eye, Ear, and Throat Hospital developed in 1962. This association has been enhanced by affiliation with Maryland General Hospital as their Eye, Ear, Nose, and Throat Department. Through the efforts of Dr. Albert Steiner, who has been the constant guide for the program, and the excellent cooperation of Mrs. Wilke, Dr. Tarr, and the whole Maryland General Hospital administration, a most productive, integrated program has resulted. For the past four to five years, the director of the Division of Otolaryngology education, Dr. Dole Baker, has provided the full-time teaching back-up for a very dedicated staff. The teaching program has involved three resident trainees, and numerous interns and students who have enjoyed a productive experience in the otolaryngology service at Maryland General Hospital, which serves 10,000 to 12,000 patients per year in the otolaryngology outpatient clinic and 2500 as inpatients.

The service activity, which provides the basis of the teaching program for the medical school, is extensive. Approximately 20,000 patients come under the surveillance of the staff each year. More than 700 operations for ear, maxillofacial reconstruction, and cancer of the head and neck are accomplished each year. With the 10 to 12 thousand patients seen at Maryland General Hospital, a very considerable exposure and service result.

The Speech and Hearing services represent a referral center for communication disorders for a large part of the state. A considerable portion of this activity is in cooperation with the Children's Evaluation Clinic of the Department of Pediatrics. The evaluation and guidance for the appropriate educational development of children with learning disorders has been pioneered and nurtured in this state by the devoted efforts of Miss Regina Cicci, Coordinator of the Speech and Hearing Services.

An active program of rehabilitation of patients with voice disorders and loss of voice from trauma and surgery assists groups of 10 to 15 patients on a regularly scheduled basis each week. A hearing aid library provides a complete choice of the current instruments available on the market today. A continuous program of hearing aid fitting for appropriate hearing loss is an active service.

The speech and hearing services provide an ongoing clinical practice area for graduate students in the Speech and Hearing programs of College Park and other campuses in the community. Many appropriate institutions on the Atlantic seaboard and more particularly the colleges and workshops of the state seek the assistance of the Speech and Hearing staff.

The trend for the future in research holds considerable interest in such areas as combination therapy of cancer, which we are involved in an active way with BCRC and Dr. Elias of the Department of Surgery, Oncology Division. The techniques and developments of plastic and reconstructive surgery of the maxillofacial area represent a significant aspect in the field of Otolaryngology, and major interests in this area exist among most practitioners.

Finally, we are very enthusiastic about our program of research in auditory function, particularly in regard to the study in clinical settings of evoked potentials, which, in its most sophisticated aspects at the present time, is directing attention toward brainstem analysis in a way which is quite as significant as the developments of scanning techniques in Radiology. The cooperative activity currently developing with the Neurosurgical Service represents a major increase in our residents' exposure to the practice of Otolaryngology and Neurosurgery in 1976.

The future of maxillofacial and other trauma disease holds a significant potential in the development of many of the aspects of the Emergency Room and the Maryland Institute for Emergency Medicine. We are looking forward to a high degree of continued cooperative activity in both of these areas.

In regard to personnel, it has been our good fortune to have available some outstanding individuals to add to the faculty of the Division of Otolaryngology. We are certainly enthusiastic about the future for Otolaryngology at the University of Maryland Hospital. Future progress as well as past success is due to the continued cooperation of the graduates of the Medical School and the fine efforts of the alumni of the Otolaryngology Division in local and various areas of the country who refer patients with problems of interest to us and who contribute their help and assistance in the teaching program.

Division of Thoracic and Cardiovascular Surgery

Safuh Attar, M.D.
John Hankins, M.D.
Joseph S. McLaughlin, M.D.
John Satterfield, M.D.
Steven Z. Turney, M.D.

The Division of Thoracic and Cardiovascular Surgery is responsible for the care of patients with diseases of the heart and great vessels, the esophagus, the lungs and the contents of the thorax. Secondly, the division is responsible for teaching various aspects of this specialty to medical students, residents and practicing physicians within our community. Thirdly, the division carries out an active program of laboratory and clinical investigation and public service.

The past five years have seen a marked increase in the amount of heart surgery and a marked change in the type of heart surgery performed. Five years ago approximately 90 patients were operated upon utilizing cardiopulmonary bypass. Two years ago this number had increased to 173 patients, and over 240 open heart procedures are anticipated this year. If one adds to this figure those patients undergoing various closed heart operations, mitral commissurotomy, pulmonary-systemic shunts, and pacemaker insertion, well over 300 patients with heart disorders will be operated upon in 1976.

The type of heart surgery performed has undergone great change. Valvular heart surgery has continued to increase, due predominantly to an increased incidence of aortic valve replacement, particularly for calcific aortic valvular stenosis. This probably relates to a better recognition of this entity and its dangers and to the willingness of physicians to refer such patients for operation with the knowledge that the operative risk is proportionally low. Conversely, with the decrease in incidence of rheumatic fever, the proportion of mitral valve disease has diminished, although overall numbers treated have risen.

There has been a marked change in the incidence and type of congenital heart disease treated. Some years ago it became apparent that congenital heart disease was decreasing in the United States. This relates to public health measures such as those preventing measles, abortions in high risk mothers, and the trend toward smaller families. Further, the relationship of certain drugs taken during pregnancy to the incidence of heart lesions is becoming more clearly understood. Because of a smaller case load and the necessity to concentrate expertise in this area, a section of pediatric heart surgery was created, led by Doctor Turney. This has proven eminently successful. During the past two years there have been a number of

exciting developments in this area. The technique of profound hypothermia combined with circulatory arrest and exsanguination permits corrective surgery to be performed upon newborn and premature infants. The phenomenon of ductus reopening and heart failure in hypoxic infants with the respiratory distress syndrome has been delineated. Heterograph valves, allowing correction of truncus arteriosus and other severe abnormalities, have been developed. All of these techniques and modalities have been and are being utilized at the University of Maryland. With the recent addition of a section of pediatric cardiology within the Department of Pediatrics, continued growth and development in this area is anticipated.

A little over five years ago the first patients with coronary heart disease underwent definitive operation at the University of Maryland Hospital. The numbers of these patients have increased each year, and along with this increment has come a significant increase in operative procedures in those patients with damage to the myocardium and heart valves on the basis of coronary artery insufficiency. The development and the results of such operative procedures have been truly revolutionary. Coronary artery saphenous vein bypass, usually to two or more arteries, is being carried out on an elective basis with better than a 95 percent survival rate and with a symptomatic and functional improvement rate of 90 percent or better. Ventricular aneurysmectomy, aortic and mitral valve replacement, and combinations of the foregoing with coronary artery bypass surgery have become common and the results of these complex operative procedures are better than those of simple valve replacement of a few years ago.

Surgery of the esophagus has been of special interest to the division for a number of years. Cancer of the esophagus is the eighth most common tumor. It is a highly malignant lesion with a survival rate less than that for acute myeloid leukemia. Protocols were developed for treatment of esophageal carcinoma some years ago and the results of these protocols are now becoming apparent. Essentially, the operative mortality has been reduced to approximately ten percent—nationally mortality rates are 2-4 times this level. Further, palliation and survival have been significantly improved. A number of scholarly papers have been forthcoming from this work and recently Doctor Hankins was awarded a large grant from the National Institutes of Health to continue his studies in esophageal replacement.

The recent movement of the Baltimore Cancer Research Center to the University of Maryland Hospital has proven to be a superb addition to our environment. Dr. John Satterfield serves as the division's liaison with this facility. The expertise in cancer biology, immunology and chemotherapy has greatly augmented our chest tumor program both educationally and investigationally. Additionally, there has been an increase in the numbers of pulmonary and other thoracic and mediastinal tumor resections carried out.

Scholarly research is an important function of a university and a diverse investigative program is carried out by the members of the division. Doctor Attar, in addition to carrying a significant clinical and teaching load, has gained international renown for his investigation of the chemistry of coagulation and vasoactive substances. Doctor Turney has developed a computerized pulmonary monitoring system, which is being installed in the open heart recovery room and which allows on-line determination of cardiovascular as well as pulmonary function. Doctor Hankins' investigative work in esophageal replacement is noted above and Doctor Satterfield has taken part in the cancer chemotherapy and myasthenia gravis studies carried out by the BCRC and the Departments of Neurology and Pathology respectively.

Teaching is the third limb of the equilateral triangle of university practice. Members of the Division begin teaching medical students during the sophomore year and take part in the teaching program during the students' basic surgical rotation. An elective rotation is available for seniors. Residents from the General Surgery program rotate through the service during their second and third postgraduate years. Third year residents from St. Agnes, South Baltimore General and Lutheran Hospitals matriculate for two-month periods. In addition to daily rounds, an active conference schedule is maintained. These conferences include a basic science lecture on Saturday morning presented by the divisional staff and experts from other departments, x-ray and work conference, and combined rounds with the Divisions of Pulmonary Disease and Cardiology. A journal club meets monthly. Each year "mock" thoracic surgical boards, modeled after the examinations given by the American Board of Thoracic Surgery, are held for the Thoracic Resident. During the past year four of our former residents successfully completed the American Board of Thoracic Surgery. We congratulate them on their success.

The Division of Thoracic and Cardiovascular Surgery enjoys excellent relationships with its corresponding specialities, notably the Divisions of Cardiology and Pulmonary Disease of the Department of Medicine, and the Maryland Institute for Emergency Medicine, directed by Dr. R. Adams Cowley. Further, we are fortunate to have as part-time members of our Division a group of dedicated and expert thoracic surgeons. Dr. John Miller has been Director of Tuberculosis Surgery for the State of Maryland for many years and has had great and salutory influence on pulmonary surgery at the University of Maryland. Doctors Fred Cole and Karl Mech, Jr., have been most

active in our program and many other surgeons contribute to our conferences, seminars and other teaching functions. In great measure these relationships are responsible for the success enjoyed by the Division.

The Division is proud of its accomplishments over the years, but most of all it is proud of the men and women who have worked and trained with us. We are fortunate to have highly skilled and dedicated nurses without whom no unit can function. But one must note laboratory technicians and cardiopulmonary perfusionists, dietitians, secretaries, aides and orderlies, operating room technicians, and clerks—all of whom contribute in a meaningful way to the program. Finally, we pay special tribute to our residents who eventually leave us skilled in our discipline and compassionate in their care of the sick. They are our most valued heritage.

Division of Urology

John D. Young, Jr., M.D.
Earl P. Galleher, Jr., M.D.
Edward W. Campbell, Jr., M.D.
Said A. Karmi, M.D.
James R. Powder, M.D.
Robert L. Doyle, M.D.
Louis C. Breschi, M.D.
Howard C. Kramer, M.D.
Howard B. Mays, M.D.
Robert B. Goldstein, M.D.
David S. McHold, M.D.
Louis A. Shpritz, M.D.
Stanley B. Silber, M.D.
Chawalit Suddhimondala, M.D.

Urology was made a formal Division in the Department of Surgery in 1955. Urologic Surgery previously had been integrated with general surgery, although a program had been approved for resident training in Urology and one resident had become eligible for certification by the American Board of Urology prior to 1955. With the establishment of the Division of Urology, the first geographic full-time urologist was given an office in the University of Maryland Hospital followed by active recruitment of candidates for the residency. In 1957, the Residency Program became affiliated with the Veteran's Administration Hospital, in 1969 with Mercy Hospital and in 1975 with the Maryland General Hospital. Instruction and supervision of the Residency Program has been provided by both full-time and part-time urologists who, along with the residents, provide faculty for an expanded program of teaching Urology to medical students. This under-graduate program in urologic education now includes the students in the second, third, and fourth years. An effort is made to present information on urologic disorders which are encountered by family practitioners and primary care physicians. The schedule includes discussion of urologic symptomatology, the physiology of urine transport, renal function evaluation, renovascular hypertension, contributing factors to urinary tract infections, urolithiasis, urologic trauma, anomalies of the urogenital system, neurogenic bladder dysfunction, neoplasms of the urogenital tract, disease of the prostate, and disorders of the male reproductive organs. Students receive instruction from faculty members at Maryland General Hospital and Mercy Hospital as well as the University of Maryland Hospital.

The Division has become a referral center for urologists in Maryland, as well as communities in Pennsylvania, West Virginia, and Delaware.

Since 1955, 41 residents have completed the University of Maryland Program in Urology. Of these, 17 are alumni of the University of Maryland, 15 are graduates of other American schools and nine are graduates of schools outside the United States and Canada. Three of the latter have returned to their native countries. Thirty-eight are practicing urology in the United States and Canada.

From 1960 to 1969, the University of Maryland was one of 14 participating institutions in the cooperative study of renovascular hypertension. The Division of Urology provided both the Chief Investigator and the Research Associate for this project at the University of Maryland. Segmental renal ischemia as a cause of hypertension in laboratory animals was studied by some of the Urology staff as part of the research effort in renovascular hypertension. The Division of Urology in conjunction with the Division of Radiation Therapy developed one of the first protocols for combining radiation with surgery in the management of bladder cancer.

Chronic hemodialysis was instituted at the University of Maryland Hospital by the Division of Urology in 1967. This program has since most appropriately become the responsibility of the Division of Nephrology. The Urology staff continues to participate in renal transplantation. Dr. Karmi currently performs some of the kidney transplants and is the urologic member of Dr. Fuad Dagher's renal transplantation team.

More recent urologic research included the investigation by Dr. Nasir Bashirelahi, Assistant Professor of Biochemistry in the School of Dentistry, on estrogen receptors in the cells of the normal and neoplastic human prostate. Prior to his return to Brazil in 1974, Dr. Paul Mendonca had completed a study in animals of free ureteral grafts in both the intraperitoneal and extraperitoneal environments.

A Partial List of Publications

Michael, R.H., Dorfman, H.: Malignant fibrous histiocytoma associated with bone infarcts. J. of Clinical Orthopaedics, July 1976.

Michael, R.H., Alevizatos, A.C.: Femoral neuropathy: A complication of anticoagulation. Maryland State Medical J., May 1975.

Paul, R.L., Michael, R.H., et al: Anterior transthoracic surgical decompression of acute spinal cord injuries. J. of Neurosurgery, September 1975.

Michael, R.H., Edwards, C.C., Keats, N.: The intra-articular use of amphotericin-B for local mycotic infections: a clinical and laboratory investigation. Submitted to the American Academy of Orthopaedic Surgeons for presentation and publication 1976.

Edwards, C.C., Chrisman, O.D.: articular cartilage, in The Scientific Basis of Orthopaedics, Appleton, Century, Crofts publishers, 1976.

Edwards, C.C.: The effect of hyperbaric oxygen on new bone formation in rabbits: Trans. Orthopaedic Research Society, Vol. I, 48, 1976.

Edwards, C.C.: The threshold of hyperbaric pulmonary toxicity in rabbits. Submitted 1976.

Ger, E., Dall, D., Miles, T., Forder, A.: Bone cement and antibiotics. Submitted 1976.

House, H.C., Ciotola, J.: Evaluation of the vasculature of the hand. Accepted for publication, Maryland State Medical J., 1976.

House, H.C., Kutz, J.E., Kleinert, H.E.: Treatment of gunshot wounds of the hand, Proc. J. Bone and Joint Surgery, accepted for publication, 1976.

House, H.C., Beck, B.: Evaluation of the painful wrist. Accepted for publication, Maryland State Medical J., 1976.

House, H.C., Bloem, J., Whitten, T., Volatile, M.: Treatment of infections of the hand. Submitted for publication 1976.

McLaughlin, J.S.: "Complications of Thoractomy Incisions"—Chapter in Textbook, *Complications of Thoracic Surgery*, Editors: Ellison, Cordell and McLaughlin.

Attar, S., Kirby, W.H., and McLaughlin, J.S.: Publication of a book entitled *Thoracic Trauma*, two chapters entitled: "The Forces Producing Certain Types of Injuries" and "Delayed Recognition and Late Complications of Thoracic Trauma." In press by Year Book Publisher.

Turney, S.Z., Attar, S., Ayella, R., Cowley., R.A., and McLaughlin, J.S.: Traumatic aortic rupture: a five year experience. Presented at the annual meeting for the American Association for Thoracic Surgeons, Los Angeles, CA, April, 1976.

Hankins, J.R.: Blunt Chest Trauma: The First Hours. Network for Continuing Medical Education video tape program, March 1976.

Stechmiller, B., Satterfield, J.R. and Associates: Maturation of metastatic teratocarcinoma following chemotherapy to a mass pathologically indistinguishable from a mediastinal enteric cyst. (In press, Chest, 1975)

Report edited by Thomas Jackson, B.S., and Merrill J. Snyder, Ph.D.

Special thanks to Dr. George Robert Mason, Mr. George Sideris, and all contributing members of the Department of Surgery.

Photographs by Philip Szczepanski

101st MEDICAL ALUMNI REUNION

Jean D. Goral

Following is a "thumb nail sketch" of the activities during the Medical Alumni Reunion, June 2 and 3, 1976.

The celebration began on Wednesday, June 2, at the Hunt Valley Inn in northern Baltimore County. 410 members and guests registered for the event, including 95 members of the 1976 Class and their guests, eight members of the 1926 class, University and Medical School officials, faculty, friends and 209 Alumni and guests.

The evening started with a reception, followed by a procession of the Class of 1926, who were escorted to their tables by members of the Board of Directors. After dinner, Dr. William H. Mosberg, Jr., President of the Medical Alumni Association (who, incidently, proved to be Toast Master Extraordinaire), presented the Honor Award and Gold Key to Dr. William H. Triplett, who expressed his appreciation in his own inimitable and delightful manner.

Dr. Mosberg announced the names and gave a brief biographical sketch of each member of the 1926 Class, who was presented a certificate by the President of the 1976 Class, Dr. Harry C. Knipp.

Dancing followed for the remainder of the evening.

Thursday morning, June 3, Dr. Mosberg opened the exercises by introducing Dr. Albin O. Kuhn, Chancellor of the University of Maryland at Baltimore, who greeted the membership and gave a brief outline of the financial status of the University of Maryland and pending changes. Dr. John M. Dennis, Vice Chancellor for Health Affairs and Dean, School of Medicine, welcomed the members back to the University and brought them up to date on the activities of the Medical School, enrollment, admissions, student aid, and the new facilities under construction on the campus.

Dr. Mosberg presented a 50-year certificate to Dr. Max Trubek, who was unable to attend the banquet the previous evening.

The Scientific Program which followed was based on a historical theme and featured Mr. Blaine Taylor, Managing Editor of the Maryland State Medical Journal, who spoke on "Health and History—How Illness of Leaders Changed the World," and Dr. Roger H. Michael, Associate Professor of Orthopaedic Surgery of the University of Maryland School of Medicine, who presented a narrated slide presentation entitled "Sketches of Davidge Hall and its Founder." (It should be noted that the Davidge Hall Restoration Committee and the Medical Alumni Association are very grateful to Dr. Michael, who even though not an alumnus, has taken a more than active interest in Davidge Hall and spent many hours in researching and producing the narrated slide presentation.)

For the first time, 25-year certificates were presented by Dr. Mosberg to members of the 1951 Class in attendance.

Approval of the minutes, the Treasurer's Report by Dr. John F. Strahan, and the Necrology by Dr. William H. Triplett preceeded the election of Officers and the nomination of members to serve on the Nominating Committee. The duly elected Officers and Members of the Board are:

President-elect:
Herbert J. Levickas, M.D. '46

Vice Presidents:
Benjamin M. Stein, M.D. '35
A. Frank Thompson, M.D. '40
Walter J. Benavent, M.D. '46

Secretary:
Wm. J. R. Dunseath, M.D. '59

Treasurer (reelected)
John F. Strahan, M.D. '49

Members of the Board:
Bernard S. Karpers, M.D. '62
John G. Wiswell, M.D. Faculty
D. Frank Kaltrider, M.D. '37

Members of the Nominating Committee:
Salvatore R. Donohue, M.D. '64
John A. Wagner, M.D. '38
William M. Seabold, M.D. '31

In lieu of a report from the Davidge Hall Restoration Committee, Dr. Mosberg referred to the Presidential Message in the February issue of *The Bulletin* which carried a lengthy summary of the inception and progress to date of the Davidge Hall restoration project. He also mentioned two current fund-raising projects: Bicentennial Pewter Plates now on sale, and prints of four paintings (three of the University Hospital at various stages and one of Davidge Hall) which will be offered for sale in the future.

Dr. Mosberg informed the membership of the resignation of Dr. John O. Sharrett, who served as Chairman of the Davidge Hall Restoration project since 1970 and whose resignation became necessary due to his inability to devote the time required to the project. Dr. James A. Roberts, incoming President, will appoint a chairman in the near future. Dr. Mosberg expressed the appreciation of the Association to Dr. Sharrett for his efforts and the great amount of time he had spent on behalf of the Medical Alumni Association.

Dr. William J. R. Dunseath gave a brief report on the

(continued on page 24)

The Class of 1926 and spouses are applauded after being escorted to head table by board of directors.

Alumni Day 1976

Dr. and Mrs. Albin O. Kuhn, Chancellor, UMAB, and Dr. and Mrs. Wilson H. Elkins, President, University of Maryland.

Dr. William H. Mosberg, President, presents Gold Key Award to Dr. William H. Triplett, '11.

Mr. John Goral; Mrs. Jean Goral, Executive Administrator; Dr. Roger Michael; Dr. John A. Wagner and Mrs. Roger Michael.

The Class of 1926 is seated at place of honor. [See "Spotlight," page 27, for a list of the honored representatives of the Class of 1926.]

d and 4th generation of Knipp physicians: Dr. and Mrs. Harry C. Knipp, , and Dr. and Mrs. Harry L. Knipp, '51.

Dr. and Mrs. Richard Lavy, '60; Dr. and Mrs. Louis T. Lavy, '26; Dr. and Mrs. Norman W. Lavy, '55.

. and Mrs. James Roberts (President-elect) and . and Mrs. Raymond C. Donovan, Jr. (Alumni ay Chairman).

Dr. John W. Bowie, '76, with parents Dr. and Mrs. Harry C. Bowie, '36.

Dr. Walter Ray Hepner, III '76, with father Dr. Ray Hepner (Faculty).

ass of 1946 gathers in Hunt Valley suite.

Class of 1951 reunited . . .

Chancellor and Mrs. Kuhn, and Dr. and Mrs. Albin O. Kuhn III, '76.

Dr. Frank G. Kuehn, '50; Dr. and Mrs. Mosberg; Mrs. Salvatore R. Donahue.

A long view of the Class of '76 enjoying the banquet.

Dr. John M. Dennis, Vice-Chancellor and Dean, and Dr. William H. Mosberg inspect the fig tree planted by Dr. Dennis years ago.

Dr. and Mrs. Francis A. Reynolds, '21.

Dr. Dennis K. Wentz; Dr. G. Robert Mason; Dr. Morton I. Rapoport; Dr. Thomas Hugh Morgan.

Reunion: Class of 1931 and spouses.

Dr. Roberts presents Dr. Mosberg, outgoing President, with award of appreciation.

Dr. Mosberg presents a Twenty-Five Year Certificate to Dr. R. Kennedy Skipton, '51.

Dr. R. T. Mendez-Bryan, '51, presents Resolution of Thanks from Puerto Rican Senate to University of Maryland at Baltimore.

Dr. Max Trubek, '26, receives his Fifty Year Award from Dr. Mosberg at Business Meeting.

NOTE: If you desire 8 x 10 glossy prints of any of the photos in this section, please designate the number(s) of the photos, tell us how many you want, and send $3.00 for each print, with your check payable to Medical Alumni Association, 522 W. Lombard Street, Baltimore, Md. 21201.

Honor Award and Gold Key 1976

The University of Maryland Medical Alumni Association presented the Medical Alumni Honor Award and Gold Key to William Hansford Triplett, June 2, 1976.

Dr. Triplett was born in a farm house in the rural area of Webster County, West Virginia, October 6, 1887. He was educated in the public schools of the area and, in 1901, served as a page in the West Virginia House of Delegates.

Dr. Triplett entered Baltimore Medical College in September 1907. He spent the five years after his graduation in 1911 in the coal fields of southern West Virginia. He worked part-time in West Virginia Miners Hospitals No. 1 and 2 but was primarily engaged in general practice.

After graduating from the Army Medical Reserve Corps Officers Training Course at Fort Ogelthorpe, Georgia, Dr. Triplett served overseas in 1918-19. Upon his return to the U.S. in 1919, he was encouraged to move to Baltimore by Dean Rowland. He spent six months working in the laboratory of Dr. Howard Maldeis and then moved his general practice to the 1300 block of Lombard St.

Dr. Triplett joined the National Guard in 1920 and was assigned to the 104th Medical Regiment, then undergoing organization. He assumed command of that organization when it was activated in February 1941.

Dr. Triplett served as a surgeon in the Twenty-ninth Infantry Division from 1941-43. In a hospital in Oxford, England, he was diagnosed as having a coronary occlusion and he returned to the U.S. in March 1943.

After five months as a patient in the Walter Reed General Hospital, Dr. Triplett assumed command of the ASTP Unit, University of Louisville School of Medicine. He was discharged from military service in April 1945.

In 1950, Dr. Triplett served simultaneously as President of the Association of Military Surgeons—United States and as President of the University of Maryland Medical Alumni Association. He was Executive Director of the Alumni Association from 1954 to 1969.

Dr. Triplett, a Presbyterian, was treasurer of the Hunting Ridge Church for twelve years. He was active in Veteran, Fraternal and Alumni affairs until the death of his wife of fifty-three years in 1969.

In presenting its Honor Award and Gold Key to Dr. William H. Triplett, the Medical Alumni Association recognizes his outstanding contributions to medicine and his distinguished service to mankind.

101st Medical Alumni Reunion (continued)

progress of the Ad-Hoc Advisory Committee (which after a change in the Constitution will become a permanent committee), and stated the purpose and function of its formation.

Dr. Mosberg asked members who have old photos of the school, its classrooms, its people, etc. to please send them to Dr. John A. Wagner for reproduction. (You may send photos to the Alumni Office for forwarding to Dr. Wagner.)

Dr. Mosberg expressed his appreciation for the privilege of serving in office for the past year, and to the Board of Directors and the Alumni office staff for their cooperation.

Dr. James A. Roberts, President 1976-77, was introduced, whereupon he presented an engraved scroll to Dr. Mosberg in expression of the gratitude of the Association for his efforts.

Dr. Roberts introduced Dr. R. T. Mendez-Bryan, Class of 1951, who presented a Resolution from the Puerto Rican Senate thanking the University of Maryland for its contribution in providing dental and medical training for students from the Commonwealth of Puerto Rico.

Following adjournment, the Annual Alumni Luncheon was served at the Circle One Restaurant at the Holiday Inn.

The Alumni activities culminated in a Reception which was held Thursday evening, June 3, at Davidge Hall. The balmy June evening was enjoyed by members of the five-year classes, Alumni, friends and faculty members, and further enhanced by delicious hors d' oeuvres and abundant drinks.

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE CLASS OF 1976

Sherry W. Abboud, M.D.
Stephen P. Adams, M.D.
Lawrence W. Adler, M.D.
Timothy E. Bainum, M.D.
Leonard P. Baker, M.D.
Christopher E. Bald, M.D.
Roger S. Barclay, M.D.
William W. Basham, M.D.
Kevin R. Bedell, M.D.
Steven M. Berlin, M.D.
David B. Binder, M.D.
Damian E. Birchess, M.D.
William D. Blake, Jr., M.D.
Lawrence F. Blob, M.D.
Mark E. Bohlman, M.D.
John W. Bowie, M.D.
Janet F. Brown, M.D.
William G. Brown, M.D.
Peter C. Cary, M.D.
Ophelia B. Clarke, M.D.
David D. Collins, M.D.
Jonathan E. Cooper, M.D.
Michael E. Cox, M.D.
Richard M. Dasheiff, M.D.
Jeffrey M. Davis, M.D.
Gurudarshan S. Debuskey, M.D.
Vincent W. DeLaGarza, M.D.
Anne P. Denham, M.D.
Phillip M. Dennis, M.D.
Edward F. Driscoll, M.D.
Francis C. Drury, M.D.
Robert S. Ettinger, M.D.
Christopher J. Feifarek, M.D.
Ellen B. Feifarek, M.D.
Isadore A. Feldman, M.D.
Hubert L. Fiery, M.D.
Robert S. Fish, M.D.
William G. Flowers, M.D.
Allan D. Friedman, M.D.
Jose R. Fuentes, M.D.
Randall B. Garber, M.D.
Fred C. Gebhardt, M.D.
A. Marcus Gerber, M.D.
Barry I. Ginsberg, M.D.
Dennis S. Ginsberg, M.D.
Stephen M. Gleason, M.D.
Allan S. Gold, M.D.
Christopher D. Gordon, M.D.
Lenita N. Gorrell, M.D.
Darrell M. Gray, M.D.
John J. Griffin, M.D.
Earl W. Grogan, Jr., M.D.
Edwin M. Grollman, M.D.
Ira E. Hantman, M.D.
Walter R. Hepner, III, M.D.
James A. Hill, M.D.
Michael C. Hoffman, M.D.
Michael A. Hurwitz, M.D.
Gary M. Jacobs, M.D.
Danae M. Jeffrey, M.D.
Rodney A. Johnson, M.D.
Emerson R. Julian, M.D.
Richard A. Kaplan, M.D.
Patricia D. Kellogg, M.D.
Jacqueline Kelly, M.D.
Sebastian A. Kent, M.D.
Robert F. Kerns, M.D.
Dean Kim, M.D.
William D. King, M.D.
Bradford A. Kleinman, M.D.
Harry C. Knipp, M.D.
Charles L. Knupp, M.D.
Mark H. Koury, M.D.
David L. Kreisberg, M.D.
Albin O. Kuhn, III, M.D.
Dorothy M. Kushlis, M.D.
John G. Lavin, M.D.
Hattie Mae Leath-Gaines, M.D.
Nelson R. Lehman, M.D.
Dennis W. Lennox, M.D.
Victor D. Lerish, M.D.
Barry K. Levin, M.D.
Barry E. Levy, M.D.
Robert T. Liberto, M.D.
Kuo-Kuang Lin, M.D.
Geoffrey B. Liss, M.D.
Bruce E. Lockman, M.D.
Lani Majer, M.D.
Robert H. Major, M.D.
James E. Mark, M.D.
David G. Martin, M.D.
Robert D. Mathieson, M.D.
Harry A. Mayer, M.D.
Eva H. McCullars, M.D.
Arnold B. Merin, M.D.
Stanley G. Middleton, M.D.
Michael S. Miller, M.D.
Richard P. Moser, M.D.
James S. Novick, M.D.
Wallace B. Obenshain, M.D.
Murray D. Pearlman, M.D.
Richard B. Peters, M.D.
Gary P. Posner, M.D.
Marc S. Posner, M.D.
Thaddeus P. Pula, M.D.
Robert N. Pyle, Jr., M.D.
Suzanne Ray, M.D.
Howard N. Reynolds, M.D.
Bridget C. Roberts, M.D.
Barry S. Rose, M.D.
Gerald M. Rosen, M.D.
Larry R. Rosenthal, M.D.
Mitchell H. Rubenstein, M.D.
William F. Ruppel, M.D.
Charles N. Schoenfeld, M.D.
David A. Shaller, M.D.
Robert J. Shalowitz, M.D.
Melvin Sharoky, M.D.
Martin J. Sheridan, M.D.
Moshe J. Shmuklarsky, M.D.
Sharon D. Sibert, M.D.
Jay B. Sigel, M.D.
Bruce A. Silver, M.D.
Gary Simon, M.D.
Lee S. Simon, M.D.
David S. Siscovick, M.D.
Boyd J. Slomoff, M.D.
Blaine E. Smith, M.D.
Mary Ann Sourwine, M.D.
James W. Srour, M.D.
Jay C. Starling, M.D.
Jerry N. Stein, M.D.
Harry W. Strahorn, M.D.
Ronald J. Sweren, M.D.
Bruce L. Tanenbaum, M.D.
William B. Tauber, M.D.
Richard F. Timmons, M.D.
Joseph R. Tiralla, M.D.
John H. Verhulst, M.D.
Barry N. Vogelstein, M.D.
Barry S. Walters, M.D.
George H. Wathen, M.D.
Deborah F. Weber, M.D.
Norden M. Weingarten, M.D.
James W. Wheatley, M.D.
Joan E. Whitehouse, M.D.
Susan M. Willard, M.D.
Pamela A. Wilson, M.D.
Daniel J. Winn, M.D.
Bruce C. Winnacott, M.D.
Samuel J. Yankelove, M.D.
Benjamin K. Yorkoff, M.D.
Miriam M. Yudkoff, M.D.
Arno L. Zaritsky, M.D.
Joseph W. Zebley, M.D.
Robert G. Zeller, M.D.

PRESIDENT'S MESSAGE

James A. Roberts, M.D.

Dr. James A. Roberts, '46, has been elected the 1976-77 President of the University of Maryland Medical Alumni Association.

Dr. Roberts was born February 12, 1922, in Westernport, Md. He graduated from Bruce High School in Westernport in 1940. He received his B.S. degree from the University of Maryland, College Park, in 1944 and graduated from the University of Maryland School of Medicine in March, 1946.

In 1947, after completing his rotating internship at Mercy Hospital in Baltimore, Dr. Roberts served as Ward Medical Officer, Jacksonville, Florida Naval Air Station. He was Assistant Resident in Medicine at Mercy Hospital in 1949-50.

Dr. Roberts received a Fellowship in Medicine at the Johns Hopkins Hospital from 1950-52. He began his practice in Internal Medicine in Silver Spring, Maryland, in 1952. The following year he was certified by the American Board of Internal Medicine.

Dr. Roberts has been a member and has held offices and committee jobs in the Montgomery County Medical Society since 1952. He joined the Medical and Chirurgical Faculty of the State of Maryland in 1952 and has served as a delegate from Montgomery County and on committees. He also belongs to the American Medical Association, the American Society of Internal Medicine and the Southern Medical Association.

Dr. Roberts has been an active member of the staff of Holy Cross Hospital since it opened in 1963 and has held sub-presidential offices there. He has served on the staffs of Suburban Hospital, Bethesda, Md., and Washington Adventist Hospital since 1952.

Dr. Roberts and his wife, Mary Adele, have four daughters and three sons whose ages range from fourteen to twenty-seven years. He attends St. Michael's Catholic Church in Silver Spring and has been a member of the Knights of Columbus since 1952. He is a Terrapin Club Member of the University of Maryland and has been an active tennis player since 1971. He has contributed eight gallons of blood to the American Red Cross.

By way of introduction, my name is Jim Roberts, and I am honored to be the 102nd President of this wonderful organization (which has no duplicate). I am from Western Maryland, attended pre-med at the University of Maryland, graduated from the Medical School in 1946, trained at Mercy and Hopkins and have practiced in Silver Spring, Maryland since 1952 as a solo internist. Mary Adele, a Mercy Hospital R.N., and I were married and became the parents of seven healthy children. I am proud of the training that I received at the University of Maryland Medical School; it made the practice of medicine exciting and offered a great challenge to me.

My introduction into Medical Alumni activities began with Medical School and Class Reunions which started seriously for me in 1961. The Class of 1946 had a post-Alumni Day Reunion in Williamsburg in 1971, and 1976 was highlighted by a glorious five-day stay in Puerto Rico at the Dorado Beach Hotel.

Congratulations are in order for Bill Mosberg for an outstanding job as President last year, and we will look forward to his being an active member of the Board of Directors for the next two years.

I also wish to congratulate the new Officers and Members of the Board of Directors (shown elsewhere in this publication).

Now, I must thank you, the reader, who has taken the trouble to come this far and hope that I will see you at the next Alumni Reunion, June 1 and 2, 1977. Incidently, it is not too early to plan for the 1977 Reunion, especially if you are a 50-year or 25-year graduate, and if you are in a class celebrating a five-year reunion starting with 1932 or, hopefully, earlier.

Alumni Day 1976 was the usual exciting event, especially the Annual Banquet at the Hunt Valley Inn, with an outstanding and interesting acceptance speech by the remarkable 89-year Honor Award and Gold Key recipient, Dr. William H. Triplett. Bill Mosberg did a truly professional M.C. job during the program, despite harassment by members of the Class of 1946. (For details of Alumni Day activities, see pictorial and written reports elsewhere in *The Bulletin.)*

To those members who made contributions toward paying for the invitation to the Senior Class, I thank you on behalf of the Seniors and the Board of Directors.

Your Alumni Association is growing stronger and currently there are about 2150 active, i.e. dues paying, members from a total of approximately 4800. How-

ever, as time goes on, there is an ever-increasing need for Alumni support of the Medical School, so I ask that you take time to send your $20 for Alumni dues for the current year.

Our current By-Laws have been amended to include into active membership physician members of the Medical School Faculty and any physicians who received training at the University of Maryland Medical School affiliated hospitals. Non-physician members of the Medical School Faculty are also eligible for Associate Membership, but are denied the right to hold office or vote. I extend a cordial invitation to the above mentioned to join the Medical Alumni Association and make the "happy family" even bigger and more effective.

Davidge Hall has been standing since 1812 and will continue to serve as a city, state and national historic site, and a worthy symbol of the University of Maryland Medical School. Despite "slow" progress over the past 15 years, there has been "solid" progress and, currently, the architectural and research portion is in the final stages. Please be patient with us, even though you can't see one iota of change in the physical structure of this famous hall. You have been asked in recent months to purchase Bicentennial Commemorative pewter plates from which monies will go into the Davidge Hall Fund, but this will certainly not solve all of our financial problems toward restoring Davidge Hall. In addition to maximum effort by the Medical Alumni Association, we will also be asking help from business, industry and the community in general.

One of the major decisions of the Board of Directors during this past year was to hire an Executive Director who will be knowledgeable in the area of fund raising as well as Alumni affairs. We expect our future Executive Director to be visiting with you personally and listening to your suggestions, opinions, etc. Dr. Bill Dunseath has been very capably handling the above project, and we are all excited with the potential good that can come to the Association.

The Southern Medical Association Meeting this year will be held in New Orleans from November 7 through 10, 1976, and your Medical Alumni Association will have an official reception on Monday evening, November 8, 1976. I cordially invite all Maryland Medical Alumni, Maryland Medical Faculty members, and Maryland Medical facilities-trained M.D.'s to attend. You should receive an announcement from the Alumni office regarding time, place, etc.; or you can check for details at the Medical Alumni Registration Desk at our Marriott Hotel headquarters.

In closing this initial letter, I would like to say that the Board of Directors of your Association desires to be totally receptive to your suggestions, support, questions, etc., and we feel that the more members involved, the merrier will be the going.

In the Spotlight . . . Class of 1926

H. ELIAS DIAMOND, M.D., served his general rotating internship in medicine, surgery and obstetrics at Bronx Hospital from 1926-28. Since 1932, Dr. Diamond has worked as a Specialist in Internal Medicine and Allergy for the New York Department of Health. From 1954-69, he was a Fellow of the Royal College of Physicians in London. He held Fellowships in three major allergy societies—Academy of Allergy-College of Allergy, the Association for Clinical Allergy and Immunology, and was Emeritus in the Academy of Allergy. Dr. Diamond served as Consultant in Pediatric Allergy in the Misorcordia-Fordham affiliation and a visiting-attending in medicine (allergy) at Bronx-Lebanon Medical Center. He was also Consultant to the Children's Asthma Research Foundation in New York and an Emeritus member of the New York State Society of Internal Medicine. His special interest is *Atopic Dermatitus* in the field of Allergy and he was on a panel of experts for the Academy of Allergy post-graduate course in Los Angeles in 1957. From 1955-61, Dr. Diamond attended the adult allergy clinic, the Vanderbilt Clinic at Columbia University. He served as Regional President of the American Association for Clinical Allergy and Immunology from 1967-68. He became Vice President of the New York Allergy Society in 1970-71. He was a member of the Board of Directors of the Westchester Allergy Society from 1972-75.

DAVID M. HELFOND, M.D., retired from his forty-three years of general practice in 1969 because of back trouble. After the removal of two discs and a spinal fusion, he reports that he is now in good health and enjoying his retirement.

LOUIS T. LAVY, M.D., served his internship and residency at West Baltimore Hospital (now Lutheran Hospital). Since 1928, he has been engaged in the general practice of medicine in Baltimore. Dr. Lavy is on the staff of the Lutheran Hospital and North Charles General Hospital. Dr. Lavy has two sons who are alumni of the University of Maryland Medical School: Norman, Class of 1955, who is now Drug Regulatory Affairs Director for E. R. Squibb and Sons; and Richard, Class of 1960, who is now in practice in Pediatrics in Annapolis, Md.

H. EDMUND LEVIN, M.D., interned and was Assistant Resident in Medicine at Sinai Hospital from 1926-28. Dr. Levin practiced and taught in the Diabetic and Medical Clinic at Johns Hopkins from 1928-48. He taught in the Microbiology Department

at the University of Maryland Medical School for forty years and retired as Assistant Professor in 1968. Dr. Levin did special studies with Dr. Louis Katz in Chicago in electrocardiology in 1944. Dr. Levin is still practicing Internal Medicine on a limited time basis.

JOSEPH LEVIN, M.D., was Attending Physician and Attending Cardiologist at Newark Presbyterian Hospital, Newark, N.J. He is currently Senior Attending Cardiologist at this hospital. Dr. Levin was also Attending Physician at Newark City Hospital (now Martland Hospital of N.J. College of Medicine and Dentistry). He is now an Emeritus Physician at this hospital. He also served as Chief of Services at Newark City Hospital. Dr. Levin is now retired from the practice of Internal Medicine and Cardiology.

ALBERT F. MORICINI, M.D., did postgraduate studies at the University of Pennsylvania Graduate School of Medicine where he taught for twenty-two years. He became diplomate in Otolaryngology in 1937. Dr. Moricini served four years in military service during World War II as a Lieutenant Colonel. He is a member of the Mercer County (New Jersey) Medical Society, the American Medical Association, The American Academy of Opthamology and Otolaryngology, the New Jersey Academy of Opthalmology and Otolaryngology, and is an officer in the Medical Society of New Jersey.

PAUL SCHENKER, M.D., was a member of the staff of West Baltimore General Hospital (now Lutheran Hospital) from 1926-29. His thirty-nine year private practice in Surgery and Gynecology began in 1929. He also served on the Surgical Service at Lutheran Hospital, training young surgeons. Since 1968, he has worked for the Veterans Administration.

WILLIAM SCHUMAN, M.D., served his internship and residency in obstetrics at Sinai Hospital of Baltimore from 1926-28. The following year he did his postgraduate training in OB/GYN at Chicago Lying-In Hospital. He began his forty years of private practice in obstetrics in 1929. During that time he was a member of the attending staff in obstetrics at Sinai Hospital, where he is now on the Emeritus staff. In June of 1947, Dr. Schuman was certified as a Diplomate of the American Board of OB/GYN. From 1939-65, he was on the Visiting Staff in obstetrics at Women's Hospital. Dr. Schuman was Chief of OB/GYN at North Charles General Hospital in Baltimore from 1947-54. During the following eleven years, he was attending obstetrician at North Charles General Hospital, where he founded and directed the Postgraduate Institute from 1952-71. He also served as Director of Medical Education at North Charles General Hospital from 1955-71, when he became Director Emeritus of Medical Education. From 1960-65, Dr. Schuman served as Chairman of the Committee on Public Medical Education, Baltimore City Medical Society. He wrote numerous articles on obstetrical subjects. He was honored by the institution of the annual William Schuman Lecture given at North Charles General Hospital and by the naming of a lecture hall after him. From 1965-70, Dr. Schuman was a member of the Visiting Staff in Obstetrics at Greater Baltimore Medical Center, where he is now on the honorary staff in Obstetrics.

LOUIS L. WEISS, M.D., interned at Cumberland Hospital and Kingston Avenue Hospital for Contagious Diseases in Brooklyn, Brookdale Hospital Medical Center in Brooklyn. At present, he is on the Emeritus Staff in the Department of Family Practice. He has been associated with the City of New York Department of Health since 1949 in the areas of Child Health, Nutrition and School Health. He is a life member of the A.M.A., the New York State Medical Society, and the Kings County Medical Society and a past member of the American Academy of Family Practice. Dr. Weiss was awarded the Certificate of Appreciation by President Franklin D. Roosevelt and the Certificate of Merit and Selective Service Medal for uncompensated service during World War II by President Harry Truman. Since his 1972 retirement from the practice of Family Medicine in Brooklyn, Dr. Weiss has resided in Bay Harbor Islands, Florida, where he participates in community and civic affairs. His wife, Bertha, was actively engaged in the field of Education in New York City and is the author of numerous textbooks in Mathematics.

MEDICAL ALUMNI REUNION

New Orleans, Louisiana

November 7-10, 1976

(in conjunction with the
Southern Medical Association meeting)

Hospitality Suite open:
3-5:00 p.m., Sunday, November 7, 1976
5-7:00 p.m., Monday, November 8, 1976

Check at Medical Alumni registration desk for name of hotel and room number.

NECROLOGY 1975-1976

Don U. Gould, M.D.	1905	Andres E. Calas, M.D.	1929
Julius E. Gross, M.D.	1907	Leon R. Staton, M.D.	1929
Benjamin Ulanski, M.D.	1908	Harry Ashman, M.D.	1930
Walter Irving Neller, M.D.	1910	J. Howard Burns, M.D.	1930
John G. Runkel, M.D.	1910	Philip Adalman, M.D.	1931
Walter Winters, M.D.	1910	Emmanuel A. Schimunek, M.D.	1931
Lawrence A. Cahill, M.D.	1911	Hyman Chimacoff, M.D.	1932
G. Dent Townshend, M.D.	1911	Wm. Henry Eisenbrandt, M.D.	1932
Stanley Rynkiwicz, M.D.	1911	Bernard Korostoff, M.D.	1932
David Silberman, M.D.	1912	Jerome Snyder, M.D.	1932
John A. Skladowsky, M.D.	1912	George E. Lentz, M.D.	1933
Col. Alfred Mordecai, M.D.	1914	Alfred Orans, M.D.	1934
Thurman E. Vass, M.D.	1914	George F. Schmitt, Jr., M.D.	1935
Louis A. Buie, M.D.	1915	Louis J. Kolodner, M.D.	1936
Vernon Mahoney, M.D.	1915	Charles M. D'Alessio, M.D.	1937
Daniel Bruce Moffett, M.D.	1915	William M. Eisner, M.D.	1937
Theodore H. Morrison, M.D.	1915	James P. Jones, M.D.	1937
Charles R. Brooke, M.D.	1916	Irvin B. Kemick, M.D.	1937
Samuel B. Barishaw, M.D.	1917	Michael J. Dausch, M.D.	1938
D. F. Bennet, M.D.	1917	Samuel L. Fox, M.D.	1938
Fred H. Clark, M.D.	1917	Sylvan C. Goodman, M.D.	1938
Louis A. M. Krause, M.D.	1917	Detter L. Reiman, M.D.	1939
Emmet D. Moyer, M.D.	1917	Raymond C. O. Robinson, M.D.	1940
Charles W. V. Richards, M.D.	1919	John E. Esnard, M.D.	1941
Louis M. Timko, M.D.	1921	Charles Richardson, Jr., M.D.	1941
Edward N. Morgan, M.D.	1922	Richard C. Allsopp, M.D.	1943
Harry M. Sternberg, M.D.	1922	Norman B. Ream, M.D.	1943
Dominick F. Maurillo, M.D.	1924	Victor Wagner, M.D.	1945
Thelma V. Owen, M.D.	1924	George Y. Massenburg, Jr., M.D.	1946
Bennett W. Roberts, M.D.	1924	Irl Weitzman, M.D.	1946
Philip Johnson, M.D.	1926	Fred R. McCrumb, Sr., M.D.	1948
John A. Krosnoff, M.D.	1926	John L. Moyer, III, M.D.	1949
David Sashin, M.D.	1926	J. Wm. McCracken, M.D.	1953
Samuel Weinstein, M.D.	1926	C. Herbert Mueller, Jr., M.D.	1954
Samuel Wolfe, M.D.	1926	Harold W. Tracy, Jr., M.D.	1954
Joseph G. Benesuns, M.D.	1927	Wilbur C. Pickett, Jr., M.D.	1956
Gordon B. Tayloe, M.D.	1927	James S. Chase, M.D.	1956
Luther E. Little, M.D.	1928	Marvin Cohen, M.D.	1957
Vincent M. Maddi, M.D.	1928	Howard M. Wisotzkey, M.D.	1961
Fred S. Weintraub, M.D.	1928		

FACULTY MEMBERS

Charles K. Fetterhoff, M.D.

Louis F. Krumrein, M.D.

Frank J. Otenasek, M.D.

Dean's Message

John M. Dennis, M.D.

The School of Medicine has just completed another admission cycle with final selection of 175 students for admission into the 1976-77 freshman class, and 10 students for transfer from foreign medical schools into the junior class.

During the last year 873 Maryland residents and 805 out-of-state students applied for admission into the 1976-77 freshman class. Out-of-state applicants are limited by pre-screening of their academic records. The philosophy of the Administration and the Admissions Committee has been to give particular attention to residents of the State of Maryland. Therefore, the Admissions Committee faces an extremely difficult task in making the selections for each freshman year since the vast majority of the over 1600 applicants have excellent qualifications and recommendations, and present themselves well during interviews. The Admissions Committee, however, has functioned admirably during the past years since the failure rate and/or attrition rate has been well below 5 per cent each year.

A new phenomenon has emerged at the University of Maryland School of Medicine. During the junior year, an attempt is being made to matriculate as many as possible American students who have taken their first two years in foreign medical schools, considering the number of available spaces for quality clinical training within the medical school. Ten American students have been selected to enter the junior year from medical schools in Mexico, Belgium and France. Most of these students are Maryland residents. The Administration and the Admissions Committee feel particularly gratified that we are able to offer this opportunity to students who have proven themselves worthy during their first two years at foreign medical schools and have very successfully passed the first part of the National Board Examination. Not all of these students can be admitted because of limited space, but an effort is made to accommodate as many as possible.

FACULTY NEWS

New Appointments, Promotions, and Resignations

Richard C. Arbogast, M.D., Assistant Professor—FAMILY MEDICINE (promotion effective 4-1-76)

Roy A. Axelson, M.D., Assistant Professor—PATHOLOGY (appointment effective 7-1-76)

Mr. James A. Barnhart, Instructor—PHYSICAL THERAPY (appointment effective 2-29-76)

Frank M. Calia, M.D., Professor—MEDICINE (promotion effective 7-1-76)

John N. Diaconis, M.D., Professor—RADIOLOGY (promotion effective 7-1-76)

Michael L. Fisher, M.D., Associate Professor—MEDICINE (promotion effective 7-1-76)

Richard M. Foxx, Ph.D., Assistant Professor—PEDIATRICS (appointment effective 11-2-75)

Roger C. Harris, M.D., Clinical Assistant Professor—PSYCHIATRY (promotion effective 3-1-76)

Said A. Karmi, M.D., Assistant Professor—SURGERY (appointment effective 1-1-76)

Lawrence Mills, Jr., Asst. Professor—MEDICINE (appointment effective 7-1-76)

Donald M. Pachuta, M.D., Associate Professor—MEDICINE (promotion effective 7-1-76)

J. Eugene Robinson, Ph.D., Professor—RADIOLOGY (promotion effective 7-1-76)

Warren M. Ross, M.D., Assistant Professor—FAMILY MEDICINE (promotion effective 7-1-76)

Stephen C. Schimpff, M.D., Assistant Professor—MEDICINE (promotion effective 7-1-76)

Robert G. Slawson, M.D., Associate Professor—RADIOLOGY (promotion effective 7-1-76)

Dr. Judy M. Strum (Ph.D.) Associate Professor—ANATOMY (promotion effective 7-1-76)

Peter H. Wiernik, M.D., Professor—MEDICINE (promotion effective 7-1-76)

Perinklan V. Vedanrayanan, Ph.D., Research Associate—PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS, resigned 2-7-76.

ERRATUM: Six resignations were erroneously reported in the February issue of the Bulletin. The reported resignations of Drs. Ruth S. Ashman, Robert Dawson, Richard L. London, Polly Roberts, Lois M. Roeder, and Robert E. Yim were not verified in fact.

MARK YOUR CALENDAR NOW FOR THE JUNIOR OYSTER ROAST

The Medical Alumni Association will honor the Class of 1978 at an Oyster Roast on Friday, October 29, 1976, at the Hunt Valley Inn.

Local Alumni and Faculty—watch for an announcement of the Oyster Roast and take this opportunity to mingle with the Junior Class, fellow alumni, and faculty members.

Med-Chi Faculty Holds Annual Meeting

The Medical and Chirurgical Faculty of the State of Maryland held its 178th annual meeting April 28-30, 1976.

Among those conducting small group seminars were several University of Maryland School of Medicine staff members.

Cyrus L. Blanchard, M.D., Professor and Chairman, Division of Otolaryngology and Felix L. Kaufman, M.D., F.A.A.P., Instructor in Pediatrics, conducted a seminar on "Pediatric Ear, Nose and Throat Problems". W. Douglas Weir, M.D., Assistant Professor of Psychiatry and Assistant Professor of Family Practice, spoke on "Office Management of Anxiety and Depression—A Practicum".

Willard M. Allen, M.D., Professor of Obstetrics and Gynecology, discussed "Dysfunctional Vaginal Bleeding". Donald H. Dembo, M.D., F.A.C.P., F.A.C.C., Assistant Professor of Medicine, dealt with the "Rehabilitation of the Cardiac Patient".

Francis A. Clark, Jr., M.D., Associate Professor of Surgery, moderated the "American College of Surgeons Seminar in Thyroid Disease". John G. Wiswell, M.D., Professor of Medicine, participated in the discussion of the "Endocrinological Evaluation of Thyroid Disease".

Elijah Saunders, M.D., Assistant Professor of Medicine, was a participant in the discussion of "Step-care Approach to the Management of Hypertension". William G.A. Bosma, M.D., Assistant Professor of Psychiatry and Director, Division of Alcoholism and Drug Abuse, conducted a short discussion of the "Physician's Role in the Treatment of the Alcoholic Patient".

At a Lunch and Learn session, John M. Dennis, M.D., Vice Chancellor for Health Affairs, Dean, School of Medicine, discussed "Medically Underserved Areas: Can Federal Legislation Aid?". Raymond M. Cunningham, M.D., Department of Surgery, spoke on the "Present Day Management of Breast Cancer". John Hasler, D.D.S., Associate Dean for Clinical Affairs, Professor of Oral Surgery, participated in the Lunch and Learn sessions with a discussion of "The Dentist as a Member of the Primary Health Care Team". W. Douglas Weir, M.D., Assistant Professor of Psychiatry and Assistant Professor of Family Practice, spoke on "The Differential Aspects of Depression: Diagnosis and Treatment." Donald H. Dembo, M.D., Assistant Professor of Medicine, presented a "Coronary Care Update".

Arthur A. Serpick, M.D., FACP, Assistant Professor of Medicine, participated in a "Symposium on Hodgkin's Disease". Peter H. Wiernik, M.D., Associate Professor of Medicine, also participated in this symposium by discussing combined modality therapy.

R. Adams Cowley, M.D., Director, Division of Emergency Medical Services; Mr. Charles W. Garrett and John D. Stafford, M.D., Division of Emergency Medical Services, conducted discussions on "The Delivery of Emergency Health Care: Winds of Change".

Marsha Schmidt, M.D., Assistant Professor of Medicine, participated in a session on "Rheumatic Manifestations of Systemic Disease". Thomas B. Connor, M.D., Professor of Endocrinology and Metabolism, Department of Medicine, discussed "Renal Calculi—Management by the Primary Physician".

E. George Elias, M.D., Ph.D., Associate Professor of Surgery, and W. G. Bruce, M.D., Assistant Professor of Surgery, created an exhibit on "Carcinoma of the Breast".

ALUMNI NEWS

William N. Cohen, '59, Iowa City, Ia., has been cited for distinguished achievements by being named a Fellow of the American College of Radiology. The College, a professional medical society representing more than 10,000 physicians who specialize in radiology, awarded Dr. Cohen a certificate of Fellowship during its annual meeting and Convocation in Washington, D.C., the week of March 31, 1976.

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Alan James Segal, '69, Miami, Florida, was certified by the American Board of Ophthalmology in 1976. Dr. Segal is currently in private practice as an associate of Coral Gables Eye Associates, Coral Gables, Florida.

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Stuart Henry Spielman, '68, New York, New York, has passed his Boards in Radiology and is now Boarded in Radiology.

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Alfred H. Dann, '43, Sacramento, California, was certified October 21, 1975, as a Diplomate of the American Board of Allergy and Immunology, a conjoint board of the American Boards of Internal Medicine and Pediatrics.

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Neil C. Henderson, '56, Fort Lauderdale, Florida, was certified by the American Board of Allergy and Immunology, a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics.

John L. Watters, '52, Rutherford, N.J., has been appointed Corporate Vice President for Medical Affairs of Becton, Dickinson & Co., Rutherford, N.J. Dr. Watters joined the company in 1968 as Corporate Medical Director. The author of several scientific papers, Dr. Watters is a member of the Steering Committee of the Medical and Scientific Section of the Health Industry Manufacturers Association.

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Antonio Perez-Santiago, '58, Santurce, Puerto Rico, was certified as a diplomate of the American Board of Allergy and Immunology in 1975. He is the director of the allergy clinics of the San Juan Diagnostic Centers.

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Jeffrey S. Lobel, '73, Pittsburgh, Pa., is completing pediatric residency at Children's Hospital of Pittsburgh. He will begin a pediatric hematology-oncology fellowship at Yale New Haven Hospital in July, 1976.

• • •

Gary A. Belaga, '70, Baltimore, was recently certified by the American Board of Psychiatry and Neurology in neurology. He is in full-time practice of neurology at South Baltimore General Hospital.

• • •

Frank A. Shallenberger, '46, Tucson, Arizona, has been made a diplomate of the American Board of Family Practice following examinations in November, 1975.

• • •

Frederick S. Wolf, '28, Montgomery, Alabama, has been appointed Clinical Professor, Department of Public Health and Epidemiology, School of Medicine, University of Alabama in Birmingham.

• • •

Robert B. Tunney, '43, Towson, Md., was honored as one of the four "alumni of the year" at the Loyola College Alumni Association's annual awards banquet, April 27, 1976. Dr. Tunney is a diplomate of the American Board of Obstetrics and Gynecology and is a fellow of the American Colleges of Surgeons and of Obstetricians and Gynecologists, and of the Royal College of Medicine.

• • •

Charles Zimmerman, '25, Cumberland, Md., was one of twenty-four physicians honored by the Cumberland Country Club for having graduated from medical school forty or more years ago. The banquet was held September 20, 1975.

Aaron Feder, '38, Jackson Heights, N.Y., has been cited as an Honorary Fellow by the Cornell University Medical College Alumni Association. Dr. Feder has been on the faculty of Cornell since 1940 and is Clinical Professor of Medicine.

• • •

Jerry Herbst, '71, Terre Haute, Indiana, will enter practice at the Associated Physicians' and Surgeons' Group in Terre Haute, Indiana, upon completion of his residency in Urology at the University of Maryland Hospital.

He anticipates an appointment in the Division of Urology of the Indiana University School of Medicine as Instructor or Assistant Professor.

• • •

Thomas G. Barnes, '45, Greenville, Mississippi, was presented the 1976 MSMA-Robins Award by the Mississippi State Medical Association. The award is designed to provide recognition to medical practitioners for services above and beyond the call of duty. Dr. Barnes is presently a surgeon with Doctors Gamble, Brothers, and Archer Clinic in Greenville.

• • •

Marvin S. Arons, '57, New Haven, Conn., has been appointed Chief of Plastic Surgery of the Hospital of St. Raphael in New Haven. He has also been elected to the Board of Directors, Hospital of St. Raphael Foundation, New Haven, Conn.

• • •

Henry Feuer, '67, Indianapolis, Ind., was certified by the Board of Neurosurgery, May 10, 1976. Since 1972 he has served as Assistant Professor of Neurosurgery, Indiana University Medical Center, and Director, Department of Neurosurgery, Wishard Memorial Hospital. In 1973, he was appointed Director of Medical Education, Wishard Memorial Hospital.

• • •

Morton E. Smith, '60, St. Louis, Missouri, recently received the "Teacher of the Year" award from the graduating seniors of Washington University Medical School, St. Louis.

• • •

Herbert Berger, '32, Staten Island, New York, has been promoted to Director Emeritus of Medicine at Richmond Memorial Hospital. He continues to be Professor of Medicine at New York Medical College.

• • •

Joseph B. Workman, '46, North Carolina, spoke to the 178th annual meeting of the Medical and Chirurgical Faculty about nuclear medicine techniques in diagnosis and treatment of thyroid disease. Dr. Workman is currently Associate Professor of Radiology, Division of Nuclear Medicine, Duke University Medical Center.

Mary C. Burchell, '57, Walnut Creek, Cal., became a Diplomate, American Board of Colon and Rectal Surgery in 1975. She is now doubly boarded, having previously been a Diplomate, American Board of Surgery. In addition to establishing private practice, she has recently been appointed Clinical Instructor in the Department of Surgery, School of Medicine, University of California Medical Center in San Francisco. Dr. Burchell is married to Austin E. Givens, M.D., also a Diplomate of the American Board of Surgery and a 1945 graduate of the University of Maryland, School of Medicine.

• • •

John J. Bunting, '38, Houston, Texas, recently received a plaque for twenty-five years of service as a Clinical Associate Professor at Baylor College of Medicine. This was followed by receipt of a certificate noting status as a Clinical Associate Professor at University of Texas School of Medicine at Houston, for the current year.

• • •

Captain Stephen Barchet MCUSN, '56, Potomac, Maryland, has been appointed Associate Dean of the Uniformed Services University of Health Sciences Medical School along with a concurrent appointment of Executive Secretary to the Board of Regents of the University.

• • •

Nathan Stofberg, '60, Baltimore, Md., has been appointed Chairman of the Department of Radiology at James L. Kernan's Hospital. Dr. Stofberg has been practicing radiology in the Baltimore area for the last eleven years as an associate of Drs. Copeland, Hyman and Shackman, P.A. Dr. Stofberg is also an Associate Radiologist at Franklin Square Hospital and in the private practice of diagnostic radiology. The University of Maryland School of Medicine and the Johns Hopkins School of Medicine have both appointed him as clinical instructor in the Departments of Radiology.

• • •

Salvatore R. Donahue, '64, Baltimore, Md., has been appointed Medical Director of Maryland General Hospital. Dr. Donahue is formerly secretary of the University of Maryland School of Medicine Alumni Association.

• • •

George L. Morningstar, '55, Emmitsburg, Md., received one of the first two President's Medals awarded at the 168th commencement of Mt. St. Mary's College, May 23, 1976.

• • •

W. Douglas Weir, '64, Baltimore, Md., has been elected a Fellow of the American Psychiatric Association. This honor recognizes professional achievement and the continuous pursuit of excellence.

Francis McLaughlin, '39, Baltimore, Md., is finishing his term as President of the American Psychoanalytic Association. Dr. McLaughlin received his postgraduate training in psychiatry at Sheppard and Enoch Pratt Hospital in Towson, Md. In the years since graduation from the Washington-Baltimore Psychoanalytic Institute in 1946, he has contributed to psychiatric and psychoanalytic education locally as well as nationally. He has served on the faculty of the University of Maryland School of Medicine and is now associated with the Johns Hopkins Medical School. His work at the Baltimore-Washington, D.C. Psychoanalytic Institute has covered all areas including Director, Chairman of the Education Committee and training and supervising analyst. Dr. McLaughlin has been President of both the Maryland Psychiatric Society and the Baltimore Psychoanalytic Society. He has served on various committees of the American Psychoanalytic Association, the Executive Council, and he was Chairman of the Board on Professional Standards, 1969-73. He has published scientific papers on psychoanalytic education as well as theoretical and clinical issues. Dr. McLaughlin is in the private practice of psychoanalysis in Baltimore.

• • •

Damian P. Alagia, '19, Baltimore, Md., was honored by his friends, professional colleagues and patients at a gathering June 16, 1976. The event was a tribute to his fifty-nine years of service at St. Agnes Hospital. At the gathering it was announced that a new auditorium at St. Agnes Hospital will bear Dr. Alagia's name.

• • •

Edward D. Frohlich, '56, has accepted appointment as vice president of the Alton Ochsner Medical Foundation in New Orleans, La. Dr. Frohlich will direct all postgraduate medical education programs, allied health training activities and scientific research efforts at the Ochsner Medical Institutions. He will also continue his own laboratory and clinical research on high blood pressure.

• • •

James G. Zimmerly, '66, Baltimore, Md., has received the highest award from the Mid-Atlantic Chapter of the American Medical Writers Association for the best medical writing of 1975 in a professional class. The award-winning article was published in the Journal of the American Medical Association in August, 1975, and dealt with Medicolegal Considerations in the Treatment of Mammary Lumps. Dr. Zimmerly, who is Assistant Professor, Department of Preventive Medicine, at University of Maryland School of Medicine, holds a law degree and an M.P.H. degree in addition to his M.D. He graduated from the University of Maryland School of Law in 1969.

• • •

David A. Wike, M.D.,'69, has just finished a four

year residency in both anatomic and clinical pathology and has received board certification in both specialties. Dr. Wike is practicing in Twin Falls, Idaho, as of July 1976. Following graduation, he completed an internship at York Hospital in Pennsylvania and two years of research in rickettsial diseases in the U.S. Public Health Service in Montana.

Program of Continuing Education Begins Outreach Activities

William F. Jessee, M.D.

Dr. William Jessee

As the newest member of the administration at the University of Maryland School of Medicine, I am pleased to have this opportunity to describe to the members of the Medical Alumni Association some of the goals of the Program of Continuing Education for the next few years. We have entered an era in which continuing medical education has become increasingly important as a tool for the practicing physician to assist him in his continued efforts to better care for his patients, and to assure the public of his continued competency. With the cooperation of the alumni, the physicians of the State of Maryland, and the faculty of the University, it is my hope that we can make Maryland a model of interaction between peer review activities and continuing medical education. In this way, we can demonstrate to all concerned the dedication of Maryland physicians to maintaining high quality medical care, worthy of the public trust.

I joined the University of Maryland following three years with the Federal Government in the administration of the Professional Standards Review Organization (PSRO) program. In this capacity, I had the opportunity to observe first hand the effectiveness of medical audit and other peer review activities in identifying problems in the delivery of health care. Many of these problems can be corrected through continuing education programs, both for physicians and for other health care professionals. It is important that the resources we currently devote to continuing medical education be utilized in the most efficient and effective way possible. As hospitals, PSROs and individual physicians, through programs of medical audit and self-assessment, identify educational needs, it is important that the continuing medical education program of the University be able to respond to those needs. It is my hope that we can develop effective linkages between the hospitals and PSROs in Maryland and the Program of Continuing Education at the University of Maryland in order to assure such responsiveness.

Over the next year, we intend to expand considerably our Visiting Professor Program in order to provide increased and more accessible continuing educational opportunities in the community hospitals of Maryland. In addition, we will offer expanded opportunities for physicians to spend a period of several days or weeks at the University of Maryland Hospital through the Visiting Practitioner Program. We are also considering development of a physician self-assessment program and an audiovisual continuing education series. Also our courses will continue to expand and to offer opportunities for intensive learn-

UPCOMING COURSES

Visiting Practitioner Program
Visiting Professor Program

SEPTEMBER	
10-12	**Practical Neuropathology**
OCTOBER	
7, 14, 21, 28	**Selected Topics In General & Family Practice (six consecutive Thursday evenings)**
8-9	**Colon & Rectal Symposium**
23-24	**Office Psychiatry for the Family Physician**
28-29	**Aging Symposium**
NOVEMBER	
4, 11	**Selected Topics In General & Family Practice (continued)**
12	**Intensive Care of the Critically Ill Patient**
18	**Current Concepts in Orthopedics**

Please send me detailed information on the following courses:

_____

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name _____

address _____

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city state zip

Mail coupon to Dept. of Continuing Education, c/o U. OF Maryland School of Medicine, Baltimore.

ing in subject areas of interest to the practicing physician. We hope that audit committees and PSROs will inform us of the educational needs they identify in order that our courses and other activities may address those needs more directly.

Below you will find a listing of our continuing education courses for the coming quarter and a tear-off coupon which you may use to request further information about any of these courses, or about the Visiting Professor Program or the Visiting Practitioner Program. With increasing demands for public accountability, it is the obligation of the profession to assure that its members continue to practice the highest possible quality of medicine. Through regular participation in peer review and continuing medical education activities, I believe that we can fulfill this obligation. Your advice and assistance as we attempt to move toward this goal will be very appreciated. I encourage your comments and suggestions and look forward to meeting with many of you over the coming months.

Editor's Note:

Dr. Jessee joined the University as the Assistant Dean for Continuing Medical Education and Assistant Professor of Social and Preventive Medicine on July 1, 1976. He was previously Special Assistant to the Director, Bureau of Quality Assurance, HEW.

Rapoport named Senior Associate Dean

Dr. Morton I. Rapoport

Dr. Morton I. Rapoport, professor of medicine at the University of Maryland School of Medicine and chief of medicine at Loch Raven VA Hospital, has been appointed senior associate dean in the School of Medicine, effective July 1.

The new position was established by Dr. John M. Dennis, vice chancellor for health affairs at the University of Maryland at Baltimore campus and dean of the University of Maryland School of Medicine. Dr. Rapoport will have administrative and operational responsibilities in undergraduate, graduate and continuing education, including faculty appointments, space allocation and budget approval.

After graduating from the University of Maryland School of Medicine, Dr. Rapoport served his residency at the University of Maryland Hospital and has been a member of the faculty since 1967. In addition to serving on the editorial board of the *Journal of the American Medical Association* and the *Emergency Review*, Dr. Rapoport has published more than 50 scientific papers.

Sindler heads OB-GYN Resident Education at St. Agnes Hospital

Michael J. Sindler, M.D. has been appointed director of resident education in the obstetrics and gynecology department at St. Agnes Hospital, according to Sister Alberta, D.C., hospital administrator.

Dr. Sindler's appointment to the position became effective on July 1, 1976.

An honor graduate of the University of Maryland in College Park, Dr. Sindler attended the University of Maryland School of Medicine where he graduated in 1972.

Dr. Sindler completed his internship at Northwestern University's hospitals in Chicago before returning to University Hospital in Baltimore where he completed three years of residency in obstetrics and gynecology on June 30. During his last year, he served as chief resident.

At St. Agnes, Dr. Sindler will work closely in the training and education of the hospital's sixteen residents in obstetrics and gynecology.

Dr. Sindler is single and resides in Mount Washington.

UNIVERSITY OF MARYLAND BICENTENNIAL PEWTER PLATE

IN RECOGNITION OF AMERICA'S TWO HUNDREDTH ANNIVERSARY

The University of Maryland School of Medicine and the Medical Alumni Association have commissioned the Medallic Art Company to make five hundred (500) pewter plates as shown in the illustration. These plates, measuring 5½ inches in diameter, will highlight *Davidge Hall* and have been prepared as a part of America's Bicentennial Celebration.

The *Davidge Hall* Restoration Committee of the Medical Alumni Association is sponsoring a solicitation to alumni, faculty members and former house officers, as well as friends. The subscription price is $100.00 each, which is expected to realize a significant profit for purposes of the restoration. These are collectors' items and the major portion of the contribution is tax deductible (precise information will accompany the plate). The committee enthusiastically announces this subscription and needs your support.

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New Howard Hall Nears Completion

Photos by Phil Szczepanski

View from Baltimore Street . . .

Looking at Main Lobby . . .

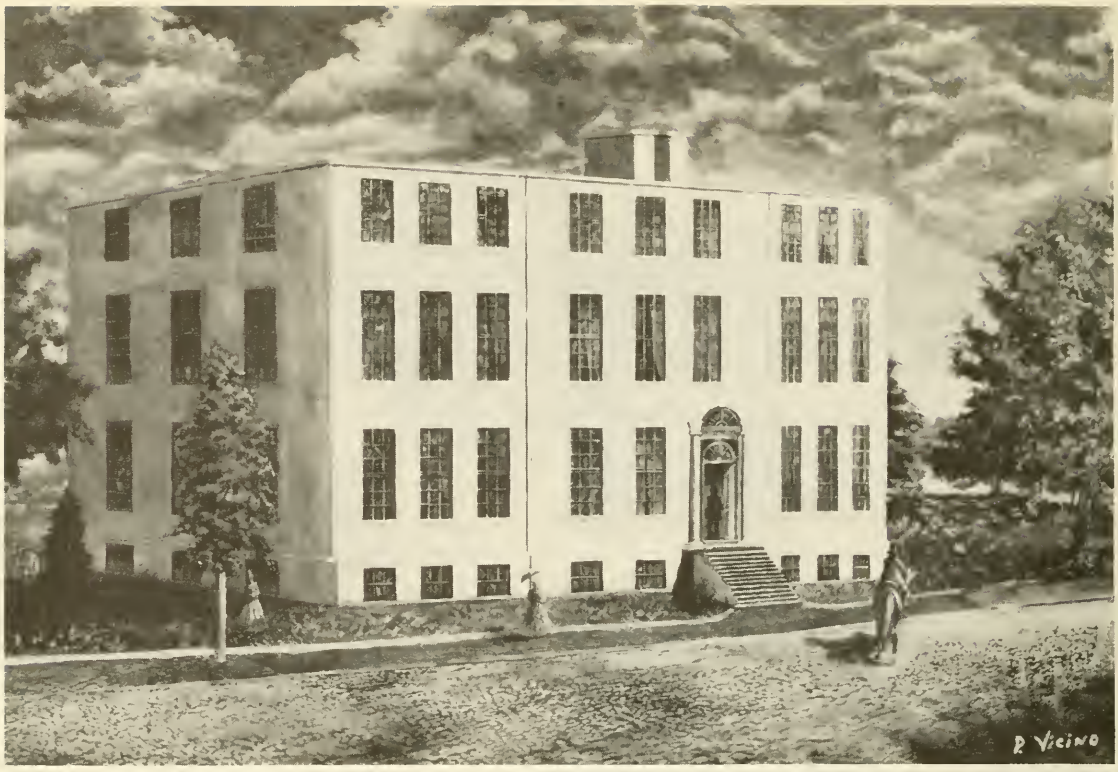
Finishing amphitheatre floors . . .

Another street perspective . . .

Wagner named Chairman of Restoration

Dr. John A. Wagner, '38, has been named Chairman of the Davidge Hall Restoration Committee.

Dr. Wagner has taken an active interest in Davidge Hall restoration projects over the years. He has pledged a continued restorative and promotional effort, and will keep alumni informed through future Bulletin reports.



University Hospital circa 1820

Davidge Hall

HISTORICAL PRINTS AVAILABLE

Several years ago two artists were commissioned to paint Davidge Hall and the three "old" hospitals: Baltimore Infirmary, 1823, and the University Hospital of 1870 and 1890.

High quality signed and numbered reproductions of these originals in a limited edition are now available by subscription. A short note relating to the building and the artists will accompany the prints.

As the edition is limited, early subscription is strongly advised.

John A. Wagner, M.D.
Chairman
Davidge Hall Restoration Committee

(Note: individual prints are not available—prints can be sold in sets of four only.)

Davidge Hall Restoration Fund
Medical Alumni Association
522 W. Lombard Street
Baltimore, Maryland 21201

Order Form

Please enter my subscription for ____ set(s) of paintings of the Baltimore Infirmary, University Hospital and Davidge Hall at $150. per set (including postage, handling and applicable taxes). My check for $_____ is enclosed.

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Please make checks payable to: Davidge Hall Restoration Fund

(Note: this is a tax deductible item.)

Glick honored as fraternity holds annual banquet

On April 4, 1976, The Graduate and Undergraduate Baltimore chapters of the Phi Delta Epsilon, comprising local medical students and physicians and surgeons, held their annual Senior Farewell banquet and dance. At this function, the fraternity honored Samuel Shipley Glick, M.D., Professor Emeritus in the School of Medicine, with a testimonial for many years of dedicated service. Both national and local medical and fraternity dignitaries were in attendance to honor Dr. Glick, who has held every important fraternity office including National President, and also President of the Board of Trustees. At this function he was presented a large inscribed silver bowl by Dr. Terren M. Himmelfarb (Univ. of Md. class '65) president of the local graduate chapter. He was also presented a plaque by Dr. Marvin Cornblath, Professor and Chairman, Dept. of Pediatrics, University of Maryland, in honor of his dedication to teaching, as well as to practicing pediatrics many years in the Baltimore and surrounding community.

Donohue appointed Medical Director of Maryland General

The appointment of Dr. Salvatore R. Donohue as Medical Director of Maryland General Hospital was recently announced by F. Duncan Cornell, President, Board of Trustees. This action was taken by the Board of Trustees of Maryland General, upon recommendation by a Search Committee comprised of representatives from the Maryland General Hospital staff and the University of Maryland Medical School. The appointment was made following approval by the Dean of the Medical School, the Medical Executive Committee and Barry Bowers, Executive Vice-President, Administrator of Maryland General Hospital.

A native of Baltimore, Dr. Donohue received his M.D. Degree from the University of Maryland School of Medicine. Following graduation in 1964, he completed a one year internship at Mercy Hospital and then entered the military, serving as Captain, Medical Corps, Army of the United States. In 1967 he returned to Mercy Hospital, completing the first and second year of his residency in medicine, followed by a third year residency at the University of Maryland. He then served the fourth year of his residency at Maryland General Hospital as Chief Medical Resident.

Dr. Donohue joined the staff of Maryland General as Director of Ambulatory Services on July 1, 1971. While at Maryland General, he has been instrumental in the growth of the hospital's ambulatory services and the development of new outpatient services, including a soon-to-be-completed General Practice Clinic.

As Medical Director, Dr. Donohue will work with and assist the Directors of Education of the Maryland General Hospital medical training program and act as liaison with the University of Maryland School of Medicine.

Dr. Donohue is active in many professional and civic organizations, including the Medical and Chirurgical Faculty of Maryland, the Baltimore City Medical Society, the Mayor's Commission on Aging and the Governor's Medical Advisory Committee for Hospital Licensing.

In addition to his new post, Dr. Donohue will continue his duties as Director of Ambulatory Services, until such time as a successor is appointed.

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Residency Appointment

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News of Another Alumnus

Academic Appointment

Interesting Historic Photographs and Artifacts

Scientific Articles

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Send To: George H. Yeager, M.D.
Editor, Alumni Bulletin
University of Maryland
School of Medicine
Room 107 Gray Laboratory
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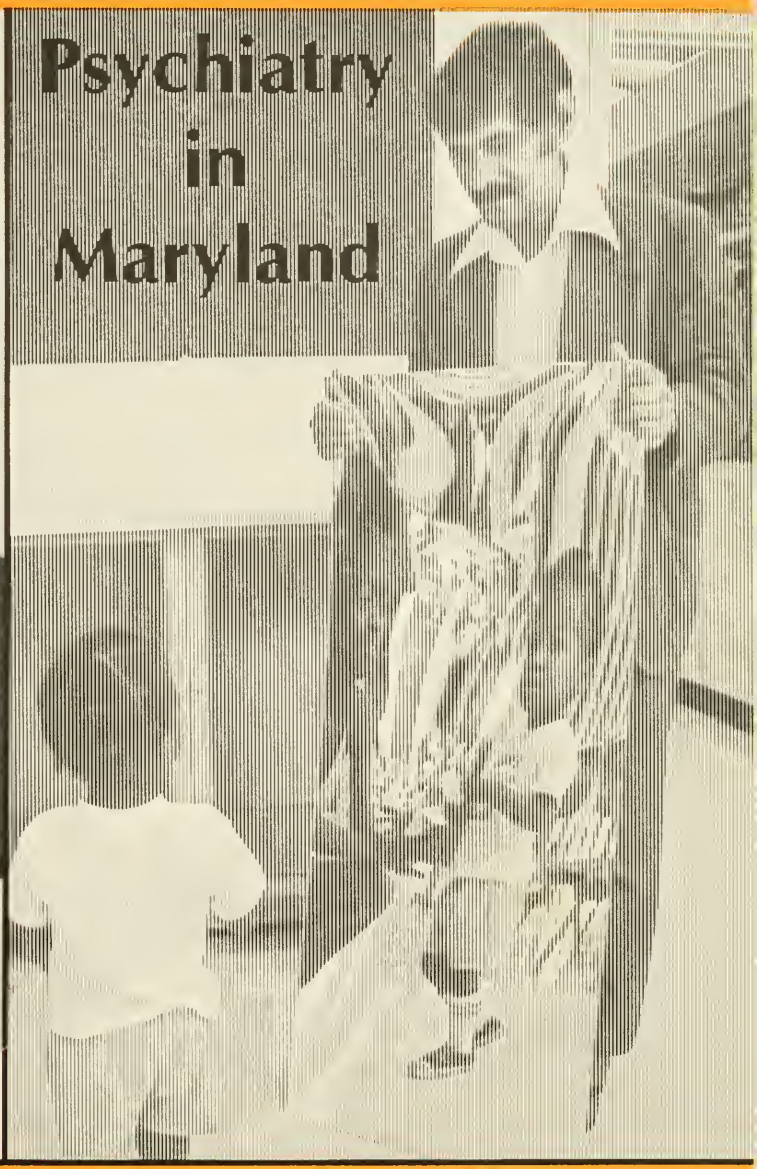
November, 1976

BULLETIN

university of maryland school of medicine

Eugene B. Brody, M.D.
Retires After Seventeen Years
as Chairman of
Department of Psychiatry

Psychiatry in Maryland



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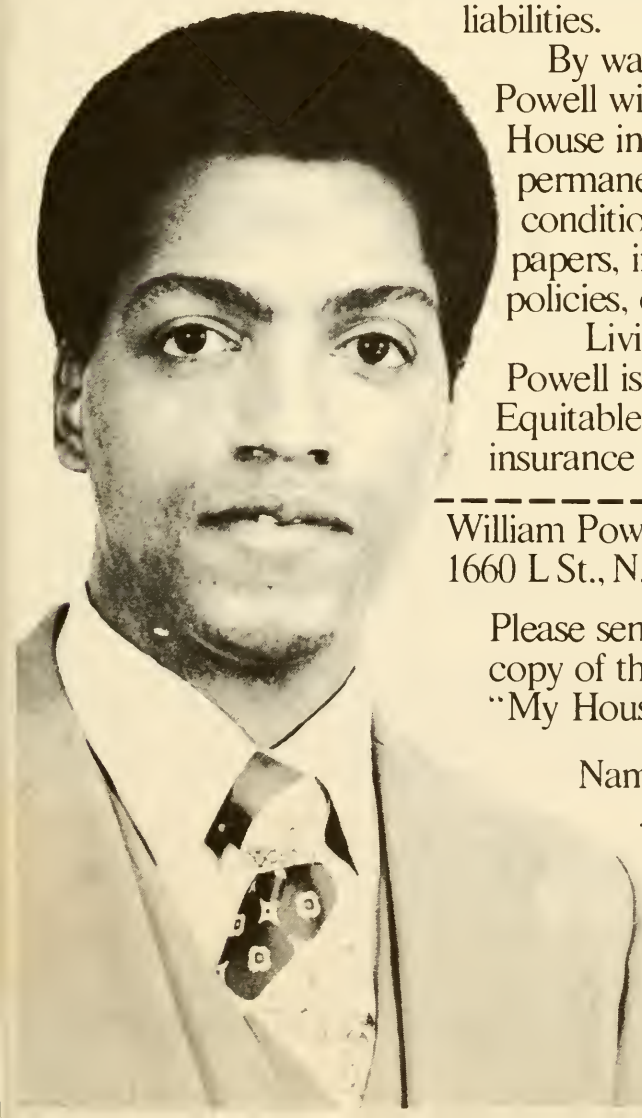

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The Publishers accept no responsibility for opinions expressed by Contributors.

COVER PHOTO: A child's reaction to self-image is studied by Taghi Modarressi, M.D., Associate Professor, Division of Child and Adolescent Psychiatry. For a full report on the history and activities of the Institute of Psychiatry and Human Behavior, see pages 4-23. Photo by Philip Szczepanski.

BULLETIN

university of maryland school of medicine

November, 1976 Vol. 61 No. 4

ERRATUM: The name of Michael Jeffries, M.D., was inadvertently omitted from the last list of the Class of 1976 published in the August 1976 issue of The Bulletin.

NOTE: Thomas Jackson is acting as editorial assistant while Mrs. Lantz is on maternity leave.

CORRECTION: The August 1976 issue of The Bulletin was Number 3 of the current Volume, and not Number 2 as listed.

Maryland Psychiatry in the Context of a Personal Career

Eugene B. Brody, M.D.[1]

This issue of the Bulletin of the University of Maryland School of Medicine devoted to psychiatry commemorates the third major transition in our departmental administration. Jacob E. Finesinger was appointed in 1949 as the first full-time Chairman of the University's Department of Psychiatry and, since its opening in 1952, Director of the Institute of Psychiatry and Human Behavior. I was appointed to these posts in December, 1959, and the third and present chairman, Russell R. Monroe, acting since I began a sabbatical leave on July 1, 1975, was appointed as of July, 1976. This account reviews our departmental growth in relation to my own experience with special reference to the evolution of psychiatry as an academic specialty in United States medical schools. It is private to the degree that it reflects the processes forming one person's professional identity, beliefs, values and personal myths. It is public to the degree that the impact of these and equivalent elements has been shared by the many individuals involved in the shaping of American psychiatry in general and of our department in particular.

Eugene B. Brody, M.D.

Personal Influences Bearing on the Maryland Experience

My first contact with Maryland psychiatry was prospective in the person of Jake Finesinger, as I later came to know him, when in 1944 as a senior medical student at Harvard I elected a month of psychiatry on his service at the Massachusetts General Hospital. Our interests coincided since I already had an M.A. in experimental psychology (with Arthur W. Melton at the University of Missouri in 1941) and considerable experience in psychophysiological research. With his broad mixture of scholarly and clinical interests, coupled with a disarmingly presented skepticism, Jake exerted a powerful force attracting me to a career in psychiatry. My residency experience at Yale and later training at the New York Psychoanalytic Institute exposed me to many influences similar to those which had formed him and made it increasingly likely that one day we would work together. Among these influences were Eugen Kahn, the first full-time professor of psychiatry at Yale and one of the legendary Emil Kraepelin's last *privatdocents*. Kahn was pragmatic and skeptical. His service was one of mixed neurology and psychiatry, viewed mainly in terms of genetic and organic factors, but he was intensely interested, as well, in the "person-in-a-situation." Leo Simmons, already a well-known social scientist, was a regular participant in departmental clinical conferences and didactic teaching exercises. Burness Moore, now in private psychoanalytic practice in New York City, was perhaps the most important personal resource for a young resident caught up in the intense and conflictful emotions attending the initial psychotherapeutic experiences. After I returned from military service the dominant figure was Fritz Redlich, who, as chairman after 1948, built one of the first truly academic psychiatry departments in the post-war era, recognizing the value of psychoanalysis, but understanding that knowledge could only be advanced by the systematic development of the behavioral sciences. I owe a great deal of my interest in social structure and behavior to Fritz Redlich and the outstanding faculty he brought to New Haven.

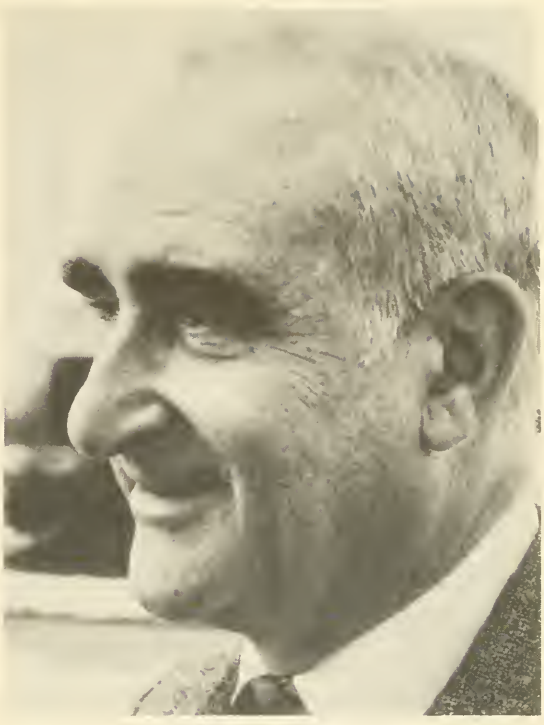
[1] It has not been possible to mention all of the colleagues and residents who have been important to me personally and professionally as co-workers in the stewardship and development of psychiatry within the University of Maryland context. My gratitude to them is unbounded. Nor has it been possible to mention the unsung heroes who stand behind the faculty—the departmental secretaries. I owe a particular debt to the tact, organization and tolerance of Eileen Potocki who has been my personal secretary for 15 years.

Many of the other experiences and people during the period there between 1948 and 1957 were significant for my later work at Maryland. Two of the most powerful, outside of my own analyst, Alfred Gross, and such figures as Ernst Kris at the New York Psychoanalytic Institute, were the late Robert Knight and Lawrence S. Kubie, both of whom were sources of personal advice as well as clinical supervision. They contributed much to the kind of psychoanalytically-oriented psychotherapeutic thinking which we hope has characterized our residents and staff here. Larry Kubie retired from his Manhattan practice and his teaching at Yale to come to Sheppard Pratt Hospital in Baltimore in 1961 and until his death in 1973 remained close to this department as a clinical professor and Editor-in-Chief (1961-68) of the *Journal of Nervous and Mental Disease* which Jake Finesinger had edited between 1957 and 1959. Another close friend from Yale was the late H.A. Robinson, a psychologist, who preceded me at Maryland arriving in the early 1950s. He became managing editor of the JNMD and together we guided it in the interim between Jake's death in 1959 until Kubie joined us in 1961. "Corney" Robinson's lingering illness after heart surgery and his death in 1966 were events which brought many of us closer together.

There were two other streams at Yale which influenced my later guidance of our Maryland departmental growth. One emanated from colleagues in psychology and the social sciences, many of whom were neighbors in the Institute of Human Relations which also housed the department of psychiatry. Of particular personal importance was the late William Caudill, a contemporary and intimate mentor in the field of cultural anthropology. Our joint research efforts on the social structure and interaction processes of psychiatric wards were the basis for later work here. He spoke in our Maryland department on several occasions and after his premature death in 1973 many of his friends contributed articles to two commemorative issues of the JNMD.

Another stream came from a group working between the department and the neurophysiological laboratories of the late John Fulton. Prominent among these were Paul MacLean and Haldor Rosvold, both now at NIMH. With Hal Rosvold and the neurosurgical help of Karl Pribram, I did my last piece of animal research—a study of the influence of a form of prefrontal lobotomy—on the social activity of a rhesus monkey colony.

By the early 1950s my relationship with Jake Finesinger had been transformed from the student-teacher to a colleagial level. I was ready, therefore, although Baltimore seemed very different from New Haven, to accept his invitation to come to Maryland as a professor in 1957.



Jacob E. Finesinger, M.D.

The Clinical Departments

Since I have spent my entire professional life on university hospital house staffs and medical school faculties, my view of psychiatry is necessarily exemplified in its status as a clinical department of an academic center. University of Maryland in 1957 had already achieved a well developed department.

The clinical departments of medical schools are unique social institutions. Among the subdivisions of modern universities they reflect with peculiar sensitivity the evolution of the society and culture of which they are part. This stems from their public significance as generators and purveyors of health personnel, knowledge and services; and their private significance as they influence and symbolize the individual perception of well-being, suffering and death. It is also on the hospital wards, clinics and laboratories for which the clinical departments are responsible that the service and scholarly functions of the medical school come together. They complement each other, but may at times conflict and must be reconciled. The final education of the physician to whom others will turn for help takes place in this potentially conflictful milieu. Responsible and compassionate participation in patient care occurs simultaneously with the personal acquisition of new knowledge and skills. This is also the place for the production of new knowledge, a traditional university function which assumes unique dimensions as it involves research with human beings whose primary need is for clinical care and whose

dignity and right to just treatment are at issue along with their medical needs.

In every instance, the clinical department is scrutinized by a variety of advocates. Professors and students have their own needs. The surrounding population must be provided with reparative and preventive health care on a basis which maintains personal integrity and autonomy. The public representatives in state government, whose vote substantially determines the academic health center's financial support, have a legitimate interest. Accountability even penetrates into such areas as the admission of students and the decision to emphasize certain types of research. The creation, shaping and management of academic clinical services reflect a continuing process of negotiation and compromise unmatched in other university units or non-university hospitals. On our own campus, with its unusual combination of professional schools including Law, and Social Work and Community Planning, the potential for creativity with its attendant complexity and need for thoughtful integration is exceptional.

The Contemporary State of Academic Psychiatry

Academic psychiatry shares the problems and opportunities of other medical specialties. The establishment of priorities, however, and the achievement of solutions are made difficult by its lack of precise boundaries. Debate still continues, for example, about the degree to which problems in living, such as marital dissatisfaction, or problems in achieving, such as school learning, fall into the proper domain of a medical specialty. Should socially deviant life-styles, or inadequate adapting or coping with stressful situations be considered "disease" in the same sense as pneumonia or arthritis, or even the schizophrenic syndrome with its cross-culturally similar behavioral core? Is it justifiable to regard patterns of thinking, acting and feeling as "pathological" in the same sense as the physiological dysfunction and anatomical lesions of medical and surgical illness?

Lawrence S. Kubie, M.D.

The role of the academic department as compared to the public hospital, the private practitioner or the research institute also remains a matter of discussion. How much of our limited resources, for example, should be devoted to general medical versus specialty education, or to education versus research?

Only since the end of the second world war has psychiatry become the focus of national public attention. This has been due to many factors including the demographic consequences of the "baby boom," especially the disproportionate rise in the number of adolescents; the leisure and need for personal direction following the economic boom; and the publicly visible behavioral corollaries of urbanization, massive internal emigration, and the rise to power and self-awareness of previously ignored minority groups. Psychiatry has also followed educational and research efforts by the National Institute for Mental Health, established in 1948, and the National Association for Mental Health. These social forces have led to two major developments in the field. One is the rise of a host of "mental health professions." Beginning with clinical psychology, psychiatric social work and nursing, these have expanded to include people from such disciplines as law, the social sciences, religion, and those with no professional background at all. All have had short or long training in one or another form of individual or group "therapy," counseling, or "personal growth." All have an investment in research on disordered behavior and ways of dealing with it. This development has been facilitated by the historical importance of an essentially nonmedical and nonuniversity discipline, psychoanalysis, in the development of psychiatry as a specialty. Psychoanalysis, too, had its major growth in the United States after the mid-1940's. No branch of medicine has been so influenced as psychiatry by a supraordinate system of training begun after basic residency and conducted in institutes outside of universities by faculties of private practitioners.

The other development has been the expansion of departments of psychiatry to become official representatives of the systematic study of human behavior (or the "behavioral sciences") within the medical school. This expansion has been vastly facilitated and encouraged by the National Institute of Mental Health. The employment of many varieties of social scientists, in addition to psychologists, social workers, biochemists and neurobiologists, is a hallmark of well-developed departments throughout the nation. It is almost amusing to look back at our prolonged, slightly obsessive discussions and trepidation before deciding, in 1971, to accurately label the department's central unit by adding the words "and Human Behavior" to the designation of the Institute.

A national move to establish departments of behavioral science independent of psychiatry has virtu-

ally died aborning with only a handful of such groups existing in medical schools today. This bespeaks the continuing vigor and central place of the clinical tradition in medical education and the importance of the case method in particular for psychiatrically trained physicians whose major role will be that of clinical practitioners. Despite intense debate, the medical model of psychiatric disorder continues to prevail over alternatives stressing social or educational etiology and treatment. The psychiatrist has not achieved, as earlier envisaged by some, a primary identity as an educational or organizational consultant. In fact, after a 25-year swing, first toward psychoanalysis and then toward social-community concern, the field—without sacrificing its diversity of research and treatment—is returning to its earlier roots in medicine and neurobiology. This move seems occasioned in part by successful application of methods of medical research to the genetic and neurochemical corollaries of disturbed behavior. It appears determined, as well, by society's increasing awareness of the cost of medical education and the possibility that some disorders heretofore treated by psychiatric physicians might be adequately dealt with by less expensively trained practitioners. This trend means that fewer psychiatrically trained physicians will pursue careers in which their medical status is significant mainly as a source of social power, legal responsibility, and the privilege of writing occasional drug prescriptions.

Maryland Psychiatry: A Confluence of Social Forces and Personal Careers [2]

The Maryland Department of Psychiatry with its Institute of Psychiatry and Human Behavior has been part of all these changes. Its status as the major human behavior resource in the academic health center was symbolized by the scientific program in November, 1952, dedicating the building then called The Psychiatric Institute. It had initially been envisaged, after much public pressure by the Baltimore Council of Psychiatric Societies and other interested groups, as a psychiatric receiving hospital for the city. It was later decided that it would have a more significant long-term impact as a center for teaching and research as well as service; with this in mind it was assigned by the state to the University as the central unit for its department of psychiatry. Dr. Finesinger's perspective on the study of human behavior was reflected in his appointment in 1949 of Robert Grenell, a neurophysiologist formerly at Yale, to direct the development of a departmental research program. Grenell, who now heads our Neurobiology Laboratories which were organized as an entity in 1960, helped design the dedication ceremonies with such speakers as Ralph Gerard, Lorente de Nó and Holger Hüyden in neurophysiology; Talcott Parsons in sociology; Alan Gregg in medical education; and O. Hobart Mowrer in psychology. Stanley Cobb in psychiatry and John Reid, a philosopher (later to become a faculty member—perhaps the first anywhere with a full-time appointment in psychiatry), were also present.

The selection of Finesinger, then a member of the Harvard faculty of the Massachusetts General Hospital under Cobb, was the enlightened choice of Maurice Pincoffs, then professor and chairman of Maryland's Department of Internal Medicine. Finesinger typified the best of the research oriented psychoanalysts who began to replace neuropsychiatrists as leading academic models after the second world war. Many had training and experience in internal medicine, having changed specialties in consequence of their military experience. Devoting major attention to university work, they were also clinically sensitive and steeped in the folklore of therapeutic practice and the literature of Freud and his followers. The intellectual foundations laid in 1949 still influence our clinical, teaching, and research programs.

The contemporary period beginning with Finesinger's appointment was preceded by almost 20 years of teaching by a part-time but nationally distinguished psychiatric faculty. In the early 1930's the entire psychiatric curriculum over the four years of medical school occupied 15 hours. Some clinical demonstrations were given at the Baltimore City and Spring Grove state hospitals and a rare student elected to go to the latter for a week's exposure to a mental hospital. Professor Ralph Truitt directed a Child Guidance Clinic and a small outpatient clinic at the University Hospital. Professor Ross Chapman came from Sheppard Pratt to lecture and with Harry Murdock sometimes brought patients to be interviewed before the medical students. For a time, Murdock, at Pincoff's invitation, made rounds with students and residents on problem cases on the medical wards, but the experiment died through lack of funds.

Truitt's major associate was Whitman Newell, like Chapman a psychoanalyst, later to become nationally prominent. Newell served as the clinical director for all University Hospital psychiatric services from 1933 to 1950. In 1937 he organized a program for third year students seeing outpatients under supervision for 30 hours. In that year, the University Psychiatric Clinic was the only one in Baltimore giving nationally approved training in child psychiatry. Newell was among the first to strongly espouse the idea of a team with a psychiatrist, psychologist and social worker. His staff in the mid-forties included the late Helen Arthur, Hans Loewald, a psychoanalyst, and Riva Novey, then a social worker, now a Maryland medical graduate, psychiatrist and psychoanalyst.

Newell, with a group of volunteer associates, also

[2] I am indebted to Drs. Robert Grenell, Ephraim Lisansky, and Riva Novey for information about the early history of the Department.

directed supervised therapeutic experience for staff and resident psychiatrists from most of the local public and private psychiatric hospitals. Among the physicians working under his supervision was Ephraim Lisansky, a Maryland graduate of 1937 (a class which yielded only one member, the late Samuel Novey, to psychiatry and then psychoanalysis). Lisanksy had become close to Newell during his war service and later, without abandoning his primary identity as an internist, undertook psychotherapeutic training to become an important link between psychiatry and the medical and surgical departments. He was a member of the search committee which brought Finesinger to Maryland and, along with Newell and Kathryn Schultz, a pioneer member of the new department. Among the first residents and faculty members, mainly after 1953, were Enoch Callaway, William Fitzpatrick, Maurice Greenhill, Klaus Berblinger, William Magruder, Virginia Huffer, Walter Weintraub, Kent Robinson, Jerome Styrt and Marion Matthews. The years 1953 to 1959 saw the basic development of the Institute clinical services (the first in Baltimore to be desegregated), the consolidation of psychiatry within the medical curriculum, and a high level of research activity especially on neuronal changes in relation to drug, alcohol and electroconvulsive stimulation. Among the outstanding students in the departmental laboratories were Jack Mendelson, Daniel Sax and Donald Brown.

Growth and Development: The Era Just Past

Jake Finesinger died at the age of 57 in the summer of 1959. In the face of this severe personal as well as professional loss my temptation to move on was strong. But when the search committee for a new chairman, headed now by Eph Lisansky, offered me the post in December of that year, I had no doubts about accepting it. Personal attachments and a feeling of responsibility for the institution had already been formed. Most important was the opportunity to carry on with Jake's clear though unexplicated goals—to understand the clinical practice of psychiatry within the context of a general science of human behavior, and to translate this understanding into action through teaching, research and clinical service.

Diversity of clinical services . . .

The 16 years beginning in 1960 have seen the emergence of the departmental network of affiliated institutions and its diversity of clinical services, research and teaching programs. These programs are concerned with data and theory from the biological sciences and their applications in medicine, neurology and pediatrics, including the study of growth and development; the social and psychological sciences including the study of social organization, culture and experimental approaches to individual and group behavior; and classical psychoanalysis, intensive psychotherapy and the variety of group dynamic and interpersonal approaches to subjective experience and objectively viewed behavior. The contributions of our own faculty were supplemented by an expansion of the already existing weekly lecture programs which brought a variety of distinguished behavioral scientists to the department during each academic year. As our appetite for conferences waxed, some years saw additional weekly meetings of the entire staff devoted to clinical or research presentations by faculty or trainees. As we became periodically surfeited and the ongoing divisional conferences seemed sufficient, these would be discontinued for a year or two. Our major effort was to keep all avenues for learning open, and most years saw some innovation or the temporary abandonment of a teaching exercise in order to give it time for renewal.

In this period we also gradually accumulated the administrative support staff necessary to allow the chairman a more effective leadership and policy-making role. This culminated in the appointment in 1972 of Norman MacLeod as our first professional departmental administrator. With some fluctuations the basic intradepartmental participating pattern was also set by the mid-1960s with a policy committee representing all divisions and units meeting weekly with the chairman and producing recommendations presented for discussion and revision at a weekly lunch-time faculty meeting, open to residents as well as senior staff. The value of food as a catalyst for intellectual exchange was established early and, with supplies readily available from nearby Lexington market, has become an important feature of many departmental meetings.

During the 16 years from 1960 to 1976, nourished in important degree by the generous support of NIMH, we participated in the nationwide growth of psychiatry that led from 4,700 specialists in 1948 to 14,000 in 1960 to an estimated 27,000 today.[1] The enthusiasm and effectiveness of our faculty is reflected in the fact that in the late 1960's the proportion of our medical students choosing psychiatry as a field was

approximately two and one-half times the national average. Our cadre of future specialists rose from a handful to a yearly total of 34 residents and fellows, and we were among the first (anticipating a nationwide move) to develop a mixed psychiatric-medical or pediatric internship. One of the most exciting developments was the development of the accelerated program in psychiatry attracting 12 gifted students in each year of medical education. This had initially been conceived as a move toward establishing a "major" area of concentration in psychiatry and human behavior which would be recognized with the granting of the M.D. It would have represented a compromise with Kubie's early vision of a doctorate in medical psychology combining elements of psychoanalytic, medical and psychological training. Such a doctorate did not seem administratively feasible, however, and the program now trains students who mainly, though not exclusively, enter psychiatric residency at an advanced level.

During the peak years, prior to a new emphasis on elective and interdepartmental work developing after 1971, 6,500 hours of didactic and supervisory faculty time were devoted to psychiatry. This covered 150 required hours in the preclinical medical student curriculum in addition to a six-week clerkship, approximately 300 elective hours, and those devoted to students in the accelerated program and interdepartmental courses. The heavy teaching load covering four years of medical school, the internship year, three of residency, and additional student summer fellowships and other special fellowships involved many individuals and services and depended upon the opening of several new clinical divisions and research programs. Many of the senior colleagues responsible for new services and programs had come to us early in their careers, electing to remain rather than accept offers elsewhere. Much of the new development and faculty recruitment was also initiated by Russ Monroe who had been a fellow house officer with me at the New Haven Hospital in 1944-45. We were fortunate to attract him here in 1960 as our first new professor, despite the offers he received from other universities.

During this period beginning in 1960, many of the former faculty continued to teach and expand their responsibilities. For several years Lisansky, with patients from the medical wards, and I with psychiatric patients introduced the freshman class to the study of interviewing and the doctor-patient relationship. Lisansky's teaching, central as well to the courses in psychotherapeutic medicine given by the department for the American College of Physicians, earned him local and international recognition. Later we moved toward a more diversified program with the initiation of a system of small group teaching and the establishment of a departmental television studio permitting instant replay and discussion, sometimes with the participation of patients themselves commenting on the screened interview, and sometimes with role-playing by students or residents. Once established, the system was supervised and grew under the supervision of Douglas Weir, and most recently Richard Schreder. Monroe developed the second-year program with the imaginative use of films for examinations with learning value; the basic design of that year still stands. We also participated in the national involvement in sensitivity and encounter experiences and several of our faculty worked with the National Training Laboratory. Robert Derbyshire, our first full-time sociologist, led the way in this area as did Monroe in his capacity as director of graduate education. Both helped establish the tradition of fall and spring encounter weekends for residents and staff at the University's Donaldson Brown Center on the Susquehanna River. Derbyshire also shepherded our first grant to support a teaching program in social science. Gerard Hunt, Richard Sarles and Dick Schreder continue as the department's leading exponents of small group process. Hunt, with the later collaboration of Jay Nolan, our staff anthropologist, and behavioral scientists from the Departments of Social and Preventive Medicine continued the development of the social science and medicine teaching programs. Social psychiatric research has been reflected in our interests in transcultural psychiatry in Brazil and elsewhere in Latin America by Manoel Penna and other colleagues; in the foreign medical graduates' project; in research on reproductive behavior and public policy in Jamaica, Eastern Europe, and elsewhere, in collaboration with such part-time faculty colleagues as Henry David; in studies such as those carried out by Jerry Hunt on citizen participation in the operations and policies of public and private mental health agencies; in Virginia Huffer's work on culture conflict in Aboriginal women in Australia; and in the personal recruitment, especially during 1962-68 with the help of the Interamerican Council of Psychiatric Associations under the joint auspices of the American Psychiatric Association and the Associacion Psiquiatrica de America Latina, of a number of younger colleagues from South American universities. The end of this era is being marked by the return of several of these latter-mentioned psychiatrists to their home countries.

For much of the past decade the medical student program has been coordinated, supervised and evaluated by George Balis, who along with Walter Weintraub also supervises the accelerated program. Their capacities are reflected in the considerable numbers of enthusiastic colleagues they have been able to attract as teachers and as participants in research assessing the teaching programs. Balis has been our effective representative in the medical school curriculum committees and major negotiator in the formation of the new social and behavioral

Departmental growth continues . . .

science sequence in collaboration with the Departments of Pediatrics and Social and Preventive Medicine.

Weintraub, in the late 1960s, succeeded Monroe as director of residency education. Earlier he had succeeded Raymond Band, who retired to private practice in 1960, as the first director or our reorganized Division of Adult Inpatient Psychiatry, one of the key training milieus for first year residents and third year medical students. Weintraub established a unique therapeutic milieu, combining psychoanalytic and social system elements, depending upon stable and devoted unit staffs. It is difficult to recall some of the simple yet fundamental changes which we made at that time, and the resistance encountered to moves such as taking the nurses out of their white uniforms in favor of street clothes, and converting the division from an essentially closed to an open service. Each unit has reflected the personality of the faculty psychiatrist-in-charge as well as his colleagues in nursing, psychology and social work. These psychiatrists in the last 15 years, all of whom began with us as residents, have included Jose Arana, Carlos Azcarate, Nathan Davis, Arthur Lamb, Leon Levin, Manoel Penna, Jack Raher, Constantine Sakles, and Lutz von Muehlen. During much of the past era the inpatient experience was influenced by the leadership of Dean Fassett, director of psychiatric nursing, succeeded by Kay Wallis. Among the key nurses responsible for maintaining the therapeutic milieu on these units have been Jennie Adams, Judy Bankhead, Debbie Clark, Kathy Cole, Judy Duvall, Joanne Fike, Ethel Myers, Sarah Perry, Gail Pomerantz and Greta Warren. Leadership in clinical psychology has come mainly from Robert Brown and in psychiatric social work—with particular attention to families—from Kay Donahoe. The daily lives of patients have been enriched by the talented activities therapy staff, led first by Roman Nagorka and more recently by Kersley Vauls, with Carl Barnes, Ben McCoy, Robyn Ramsay and Edythe Wilson.

Weintraub's successor in the post of inpatient director is Connie Sakles, another Yale medical graduate trained in psychiatry with us. Of special interest is his development during the past several years of an outstanding psychodrama program, one recently expanded and enriched by Dick Schreder.

The psychotherapeutic milieu on both the adult inpatient and outpatient services was significantly influenced by a number of part-time faculty members acting as ward consultants, supervisors of individual therapy, and seminar and conference leaders. Among the latter Otto Will exerted a significant influence for many years on our philosophy of intensive individual work with hospitalized schizophrenic patients. Explicit departmental attention to classical psychoanalysis has varied. In the years shortly after my arrival A. Russell Anderson of the Baltimore Psychoanalytic Institute and I conducted a continuous case conference and in the early 1960's I conducted a number of evening seminars on aspects of Freudian theory. Our interest is perhaps best reflected in the fact that six of our senior faculty are graduate analysts—an unusual proportion in present day departments—and several of the junior faculty are Institute students in Baltimore or Washington. We are proud of the fact that, without exception, these analytically trained colleagues are actively engaged in research as well as academic teaching and clinical supervision. This strong blending of psychoanalytic scholarship with the other fields basic to psychiatry contributes much to our departmental identity.

The major new clinical service created in the past era was the Division of Child Psychiatry, now including adolescents. Its initial nucleus, the child guidance clinic at first directed by Clara Livsey, became part of a vastly expanded system including a 14 bed inpatient unit within the Institute, a variety of specialty clinics, and affiliation with the Baltimore public schools and training programs within the state mental health system. The chief architect of the new division, with the close collaboration of such outstanding consultants as Joseph Noshpitz, was its first director, Frank Rafferty. He came to us from Utah in 1961 and remained for a decade at which time he accepted the influential post of director of the Institute for Juvenile Research in Chicago. After an interim period Rafferty was succeeded in 1973 by Stanford B. Friedman, formerly professor of pediatrics, psychiatry and psychology at Rochester. With him we have developed a broader research base for the division, including work with animals, chiefly under Michael Plaut, as well as humans, and an even closer association with community health agencies and especially with pediatrics where, with strong leadership from Dick Sarles, the department is now deeply involved in a new program of Behavioral Pediatrics as well as a pediatric psychology internship. The blending of the resources of

psychiatry and pediatrics, with the dedicated participation of many faculty members, is one of the significant departmental achievements during the past era. Within the division itself there has been a significant growth in clinical psychology with long-term contributions from Mary Jo Albright and more recently Nancy Kohn-Rabin and Sandra Leichtman. The children's inpatient unit was shaped into a finely tuned residential program between 1964 and 1974 by Ulku Ulgar, a former Fellow, and his staff. Since then it has been led by Peter Coleman, a former chief resident, and with a stronger research orientation by Alp Karahasan.

With the establishment of an inpatient service our departmental schools for children and adolescents entered a phase of intensive growth. Important figures in this respect in the mid-sixties were teachers Roland Queen and Carl Wilson, both of whom have progressed to significant educational posts elsewhere. Our first child care specialist, George Cohen, was recruited by Rafferty in 1967. Key figures in the program in the Baltimore public school have been social worker Annabel Maxwell, now approaching retirement, and psychiatrist Lee Ault, who moved to part-time status in 1974. Other colleagues important in early divisional growth and now with affiliated state agencies include Ron Barry and George Brown, both former Fellows. A major new service within the division has been the Child and Adolescent Psychiatry Clinic, headed by Martha McLaney of our social work staff since its inception in 1974. The psychoanalytic and psychotherapeutic concerns of the division continue to be coordinated and evolve with the stimulation of Taghi Modarressi.

Another new base for teaching and research established in 1969 was the Division of Alcoholism and Drug Abuse, started by Monroe and Balis as a general University Hospital program, then shifted to the department. Its precursor was the Saturday morning group for alcoholics led for many years by Isadore Tuerk. It has grown to major proportions, including a variety of service, research and teaching sections under the overall supervision of Willem Bosma, the clinical leadership—especially at the quarter-way houses—of Wendy Maters, and the scientific direction of Leon Wurmser. Along with the program in human sexuality, organized by Sharon Satterfield and Larry Donner, this division has become the core of the still-emerging nucleus of interprofessional training programs bringing the various Baltimore Campus schools together. A major service element has been the alcoholism counselors program active throughout the University Hospital in which James O'Donnell and, after 1973, Frances Fitch have been prime workers.

The Outpatient Division under Gerald Klee was transformed in the mid-1960s with the leadership of his successor, Herbert Gross, into a new and more broadly conceived Division of Ambulatory Care. The Division, with the addition of George Gallahorn, who was the winner of the first Departmental Finesinger Prize for medical student excellence in 1966, Ellen McDaniel and others, was expanded to include a variety of clinics providing services for emergency care to intensive long-term psychotherapy. These constitute training milieus for students in medicine and future specialists in psychiatry and other mental health fields at all levels. Among the key people who helped create the milieu, especially in the Open Clinic—for many years the only 24 hour walk-in facility in Baltimore—were nurses Gail Pomerantz and Lorraine Pride. Lawrence Donner has been the senior clinical psychologist for this division. At the same time the concern with providing community service was constant. This was exemplified in Herb Gross' leadership of the University Hospital Ambulatory Services Committee bringing together health "consumers" and "providers," and our function as the indispensable crisis and emergency backup for the Inner City Community Mental Health Center over many years.

During the past decade the Division of Liaison Psychiatry, led by Virginia Huffer with the association of Balis, Weir and others, has participated on a regular basis in teaching conferences on a number of University Hospital services, diminishing the need for formal consultation requests. Attention has been paid to the overall interpersonal milieu of clinical units as well as the problems of individual patients. Among the new hospital developments has been the nationally known Shock-Trauma Unit, providing many ethical as well as psychiatric problems. Nathan Schnaper has become a key person as our senior consultant in this area.

Liaison work has also progressed through the development of the family practice program with Doug Weir as our major consultant and through several special research units. The Behavioral Laboratories, established in 1968 under the leadership of James Lynch with the later collaboration of David Paskewitz, have provided one of our most significant links with medicine through studies of attachment behavior in patients in the coronary care unit. These studies have included assessments of social, psychological and sleep effects on cardiac status. The laboratories also conduct basic and clinical research in Pavlovian and operational conditioning and psychophysiology, and with the active collaboration of Huffer and Thurman Mott have extended their activities to include a psychosomatic clinical service program using biofeedback and sleep-monitoring techniques. Through them we have added to our part-time faculty the distinguished Horsley Gantt, Pavlov's last living pupil in this country.

Liaison with the Department of Neurology began in the late 1950's, especially with the work of Jack Raher

and others on seizures and borderline neuropsychiatric conditions. The role of neurological training in the education of psychiatrists occupied us for several years. We finally resolved the problem by deciding against a block rotation through neurology and in favor of a longitudinal experience over two to three years during the course of the regular residency experience. This led to our appointment in 1969, on a half-time basis, of Barbara Hulfish as our first departmental neurologist. Our competence in the area was strengthened immensely by Monroe's establishment of a departmental EEG research laboratory in 1971.

Another research unit involving a specialty clinic is the Clinical Research Program for Violent Behavior established in 1972. It has grown to national prominence under the leadership of John Lion with the more recent collaboration of Dennis Madden. Some of its concerns overlap with those of the Psychiatry and Law Program. Our initial representative in this latter field was the distinguished Manfred Guttmacher who was the chief medical counsel for the Supreme Bench of Baltimore. After Guttmacher's death in 1966 this post was assumed by Jonas Rappeport, who also holds an appointment in the Law School. A major related research program has been that on impulsive behavior initiated by Monroe in 1972 at the Patuxent Institution for repeated offenders. This is part of the stream of research which earlier produced his major work on episodic behavioral disorders.

A major need, apparent upon my arrival here, was for a systematic student mental health service. For several years we did our best to carry the increasing load of problems presented by medical students and those from the other professional schools in the course of our usual work. The first breakthrough was in 1969 when we were funded to allow Herb Gross to devote a portion of his time to this issue. By 1970 we were able to recruit our first full-time director of student mental health, Thurman Mott, already a member of our part-time faculty, who became an official part of the Baltimore Campus Student Health Service. One of our former chief residents, Thomas Cimonetti, worked with Mott to establish the Mental Health Services at the University of Maryland-Baltimore County in 1971.

Cross-cutting our divisions of clinical psychiatry have been the groups in Psychiatric Social Work and Clinical Psychology.

The development of Psychiatric Social Work into a major organizational component and a significant academic as well as clinical group has been an important departmental achievement in the past decade. The process was begun with Finesinger's appointment of Imogene Young as the first director in 1950. She developed major teaching and consulting roles for social workers with medical students, residents and psychiatric faculty and initiated a program of clinical internships for graduate social work students. When in the mid-sixties she went on leave to complete her doctorate (eventually to accept a professorship in the University of Illinois School of Social Work), she was succeeded by Leonard Press who came to us from Case-Western Reserve. Press, a gifted teacher and clinician, did much to move social work into the mainstream of individual and particularly family therapy—an area originally introduced in 1961 through such consultants to child psychiatry as Murray Bowen. After joining the senior administrative staff of our School of Social Work and Community Planning, Press was appointed to our departmental clinical faculty and continues to contribute signally to our overall teaching program. His successor and former assistant director, Donald Blumberg, stayed only a short time, but did much to broaden the group's knowledge and interest in the community mental health movement. After his departure Cecilia McCue held the service together until 1971 when we recruited Joan Scratton, who came to us from Australia by way of the Smith faculty. McCue's later death following a prolonged illness was another of the personal milestones making us all aware of each other as people as well as colleagues.

The Division of Psychiatric Social Work was reconstituted as a viable entity within the department with Scratton's arrival. For many years we had worked in the face of the constant possibility that our expanding group would be absorbed and lose its identity within the overall University Hospital Social Work Services. This struggle for separateness had its advantages, of course, since it had the usual effect of making us more cohesive. But since 1971, coinciding with other changes in the general hospital administration, and immensely aided by Scratton's organizational investment and diplomatic dealings with the general social work services, our separate talents and functions in this area appear to have been securely recognized. Under Scratton's leadership the social work internship has been expanded to as many as ten students and is now the most sought after clinical field placement in the metropolitan region. Departmental involvement with family therapy has been structuralized through the establishment of a special clinic and its mandatory inclusion in the residency with the collaboration of Henry Harbin, a former chief resident and a new inpatient unit director. Senior faculty of the School of Social Work have been recruited to our departmental part-time supervisory staff. Social workers have collaborated with departmental social scientists and those in the Department of Social and Preventive Medicine in developing and teaching the new "family" segment of the medical student social and behavioral science sequence. Members of the division have been integrated into the administrative as well as teaching and service functions of the other departmental units.

Clinical psychology was established in 1958 as a separate entity under the direction of Benjamin Pope, and since 1968 has been directed by James Mackie. Both, along with colleagues, have made major contributions to our research programs, consulting with other faculty as well as carrying out their own work. Mackie led the major project conducted by Rafferty's child division on early enrichment. For several years our clinical psychology internship, discontinued after 1974 because of the withdrawal of federal funds, was one of the leading programs in the nation.

The Inner City Project

The story of the Inner City Community Mental Health Center could occupy a special chapter. In 1966 Isadore Tuerk, then State Commissioner of Mental Health and a part-time member of our faculty, and I agreed that Maryland's implementation of President Kennedy's call for a nationwide system of community mental health centers should embody a unique collaboration between state and university to provide not only optimum direct psychiatric and psycho-social services, but also expand our production of trained personnel and new knowledge in many mental health related fields. The entire department became involved, providing housing and salaries for the first director, Lingbergh Sata—whom we recruited as a full-time faculty member—and his immediate staff, and support for a prolonged process of planning with an eminent architectural firm. We wanted a building which would be a focal and organizing point for the community, a service-oriented teaching and research center for the university and state, and home for a complex and rich linkage between the three groups: community, state mental health agencies, and university. Lindy Sata created the basic community advisory structure from which all later developments evolved. Among the early activities contributing to our concept of community mental health was a major symposium on Psychiatric Epidemiology and Mental Health Planning organized by Monroe under the auspices of the American Psychiatric Association. Changes in the state governmental organization, however, resulted in the submersion of the Department of Mental Health in an overall health grouping, Tuerk resigned, work on the building was abruptly stopped for a time, and by the time it was resumed, after intensive political effort on our part, rapidly increasing costs required major design changes and some of the initial momentum was lost. We still felt that the concept was an important one, however, and pushed for resumption, continuing to support the developing program with departmental space in Redwood Hall and backup and consultation services. Eventually, with our planning assistance, a number of local centers opened. Our official policy input after 1972 was limited to specific issues presented by the Center's Advisory Board on which we were one of many representatives on a

Architectural sketch of Maryland Psychiatric Research Center in Catonsville . . .

part-time and individual basis. And of much greater significance was the continued use of our emergency service by the Center and our contribution between 1968 and 1976 of one of the Institute wards which we operated as the indispensable inpatient unit for the Center. This unit was directed by Manoel Penna, who supplied the entire Center staff with much needed clinical advice while making his service one valued by both medical students and residents. Now, in 1976, the new building, two short blocks from the IPHB, is at last opened and partly inhabited and the need for active university involvement at all levels is apparent. We will, through our children's division, be concerned with its mental retardation as well as psychiatric functions. Its work will also be facilitated by the appointment of one of our former senior residents and a current part-time faculty member, Gary Nyman, as state director of mental health. The initial concept, although modified and delayed, will eventually be fulfilled, and our department can have a justified feeling of being instrumental in an important social development, knowing that without our efforts this important new Center would not have existed.

Affiliated Programs

As growth has occurred within the Institute, the Hospital, and the Baltimore Professional Schools Campus, we have also been involved in the development of teaching and research programs in affiliated institutions. The Sheppard Pratt Hospital has been a clinical resource for medical student education and several of its staff hold faculty appointments with us. Many of our faculty have taught in the state hospitals and our division of child and adolescent psychiatry has had an integral relation with some state units since its inception. In the early 1960's the state was given a federal grant to build and staff a research center, with the explicit understanding that the University would have an active collaborative role in its operation. This role, despite significant interchanges, remained min-

imal partly as a consequence of complications in health administration at the state level. But in the summer of 1976, following extensive consultation with our department, the state legislature transferred administrative control of the Maryland Psychiatric Research Center to the University, and we look forward to making this a productive operation.

Another significant development was the establishment of a departmental service at the Loch Raven V.A. Hospital. This began in 1971 as a drug abuse treatment unit and is gradually being expanded into a complete psychiatric service under the leadership of Charles Savage, a former fellow resident at Yale, and Daniel Johnston and Ronald Taylor, former chief residents here.

Located within the Institute but with a national base in its advisory board has been the Journal of Nervous and Mental Disease. I was fortunate in being able to follow Dr. Kubie as Editor-in-Chief after he retired from the post in 1968. Many departmental colleagues as well as others throughout the country, averaging almost 300 persons each year, have shared in the hard but rewarding work of evaluating manuscripts. Alphadeen Norris, as executive secretary, has been a key person in the operation, as have at other times Jim Mackie and Jim Lynch. In 1974 we celebrated the 100th birthday of the Journal with, among other events, a two-day conference on "The Freedom of Medical Information." This was one of the early activities in what promises to be, in coming years, a major departmental interest in the ethical and philosophical aspects of biomedical practice and research.

Transition

In the past five years, along with other academic centers, we have had to deal with the retrenchment in federal support for research and education and increasing pressure to support ourselves through our own clinical efforts. The number of psychiatric residents in the country has plateaued since 1972 at a level between 4700 and 4800, and the proportion of medical school graduates entering psychiatric residencies has dropped since that time from a level representing 10.5 percent of the graduating classes to one representing about 8.9 percent of a larger number of graduating students. It became clear by 1971 that we were entering a new era, one that demanded continuity with the past, but, as well, a renewal of our identification with medicine, a subtle shift toward the neuropsychiatric identity with expansion of our interests in the biological basis of behavior, and diversification of our clinical services with a new orientation toward the model of private practice. At the same time my own interests moved increasingly in the direction of interprofessional work and the borderlands between medicine, the social sciences and philosophy.

In 1973-74, with the prior collaboration of then Dean John H. Moxley (who moved to the University of California-San Diego in June of that year), I took a leave of absence from the chairmanship and devoted much of my time to work between the six schools on our Baltimore City Campus, moving toward establishing a more effective framework for joint intellectual and administrative integration. In this effort, carried out with the continued encouragement of the University administration, I was immensely aided by Jerry Hunt. The Social and Behavioral Studies Reference Group, formed to aid the project, included representatives from the Schools of Law, Social Work and Community Planning, Nursing, Pharmacy and Dentistry as well as Medicine. The work of this year was a catalyst, and one of the many steps in the continuing evolution of our Baltimore Campus identity as a unique professional, scientific and social resource.

During 1973-74 the department was led, as during my previous absences, by Russ Monroe. Secure in the knowledge of his willingness to serve, and the trust and respect in which he was held by our faculty, I felt increasingly that the time had come for me to return to the life of a full-time scholar and clinician. In July, 1975, therefore, I submitted my resignation as chairman. I was fortunate in being able to mark this move away from administrative responsibility by spending much of the academic year 1975-76, with the support of the Commonwealth Fund, as a Fellow of the Center for Advanced Study in the Behavioral Sciences at Stanford, California. The Center was an ideal place for reflection and creative intellectual endeavor, and an opportunity for which I am grateful.

It is a source of particular pleasure to note that the Search Committee to appoint my successor overcame its traditional doubts about an "in house" candidate and selected Monroe as the next chairman. He has an international reputation as investigator, clinician and research administrator and exemplifies the best in academic psychiatry today. During his years at Maryland he has participated in almost every aspect of our teaching and research programs and recruited several key members of our faculty. He has declined many opportunities to go elsewhere as chairman. We are grateful for his willingness to assume the tasks of holding the umbrella over the department, to maintain and help create the frame within which the rest of us can act. My own decision to remain at Maryland as a professor reflects my respect and affection for the members of our department and also my gratitude for the support and freedom which the University has always accorded me in pursuing goals and projects which I considered important. I look forward to many years of continued and creative collaboration.

Reference

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Dean's Message

John M. Dennis, M.D.

In Recognition

Eugene B. Brody, M. D.
Chairman, Department of Psychiatry
1959-1976

After 16 years as Chairman of the Department of Psychiatry and Director of the Institute of Psychiatry and Human Behavior, Dr. Eugene B. Brody requested in July 1975 to be relieved of his administrative duties so that he might devote full time to his scholarly interests, particularly teaching and research on the social-cultural influences on human behavior. He will also continue with full departmental support his important position as Editor-in-Chief of the Journal of Nervous and Mental Disease. His national and international reputation in his areas of expertise will place even heavier demands on him than in the past as a consultant to various governmental and professional agencies. These activities will continue to enhance the reputation of the Department of Psychiatry and the University of Maryland School of Medicine as one of the country's leading scientific institutions.

When one considers his accomplishments during his years as Department Chairman, he well deserves this "retirement" from administrative responsibilities. During his tenure, the Department and the Institute have evolved from youthful undisciplined exuberance to a mature organization recognized as a model department. The Department has more than tripled in size. Dr. Brody initiated the development of one of the leading Divisions of Child Psychiatry in the country. He pioneered the utilization of social scientists in medical education. He was one of the early leaders in developing community mental health programs. Because of his international interests he was committed to the residency training of foreign physicians. He was one of the founders of the Interamerican Council of Psychiatric Innovations, as well as a member of many boards and commissions concerned with international collaboration in research and teaching of psychiatry and health related disciplines. In recent years he has devoted increasing attention to the problems of interprofessional teaching and research in the academic health and human services center.

What is of even greater importance are the intangibles which make a skillful leader. He had the perspicacity to select a talented faculty and the courage to let them develop their own careers and their own programs. He did not let his own interests in the psychodynamic and social determinants of behavior constrict his appreciation of the contributions of neurophysiology, neuro-pharmacology, behavioral psychology and other approaches to understanding human beings. This was in part, perhaps, because of his own early training in these areas. The net result is a Department with high morale and stable personnel. This could have lead to organizational inertia, but his own example of consistently seeking new problems to solve and new ways to approach old problems prevented this and stimulated continued growth and diversification. He and his predecessor, Dr. Jacob Finesinger, have left a fine heritage for the new Chairman.

Russell R. Monroe, M.D.

Monroe Appointed Psychiatry Head

Dr. Russell R. Monroe has been named chairman of the department of psychiatry, University of Maryland School of Medicine, by Dr. John M. Dennis, Vice-Chancellor and Dean. A professor in the medical school since 1960, Dr. Monroe has been acting chairman of the department since July 1975.

A graduate of Yale University's B.S. and M.D. programs, Dr. Monroe took post-graduate training in medicine at Yale, a psychiatric residency at Rockland State Hospital in Orangeburg, New York, and psychoanalytic training at Columbia University.

Prior to joining the University of Maryland Medical School, Dr. Monroe served on the faculties of Columbia and Tulane Universities. At Maryland he has served as Director of Graduate Training and Director of Clinical Research. His research interests have been broad including both psychological and neurophysiologic correlates of psychotic behavior. Recently he has been studying impulsive aggressiveness in psychiatric and prison populations.

Dr. Monroe's objectives for the Department of Psychiatry in the next decade are to develop effective collaboration with other state and federal agencies. This includes joint management with the Mental Hygiene Administration of the Maryland Psychiatric Research Center and collaboration with the new psychiatric service at the Veterans Administration Hospital at Loch Raven. He hopes that cooperative programs with community mental health centers, such as the Inner City Carter Center and the Thomas B. Finan Center in Cumberland, Maryland, can be developed. Dr. Monroe believes that the department will have an increasing responsibility to educate not only medical students and psychiatrists but also family practitioners and other primary care physicians, as well as to provide continuing education for physicians already in practice.

In the Decade 1976-1986

by Russell R. Monroe, M.D.
Chairman, Department of Psychiatry
Director, Institute of Psychiatry and Human Behavior

What will the next decade bring to the University of Maryland School of Medicine, particularly the Department of Psychiatry and its Institute of Psychiatry and Human Behavior? I can say as the new chairman that I have inherited a fine department. There is a seven-story institute, a 64-bed inpatient service, an outpatient department which served 15,000 patient visits per year, a full-time faculty of 56, and a part-time faculty of 126. The Department has approximately 30 residents and teaches 170 medical students per class in all four years. The medical students rank in the upper 10% of the nation on the psychiatric sections of Part I and II of the National Boards. Our Residency Training Program graduates are not only in private practice throughout the nation but also on the faculty of many teaching institutions. We are proud that, within the state itself, our residency graduates are providing leadership in the Department of Health and Mental Hygiene. Thus, in terms of budget, residency training, educational activities and clinical services, we are one of the largest departments within the Medical School and this development has all occurred within one generation. Elsewhere in the Bulletin we list the wide range of clinical services the Institute of Psychiatry and Human Behavior can provide and we invite the alumni to utilize these services for their patients. It is a pleasure to start one's tenure as chairman with these resources.

Expansion and Improvement

The Institute, now 24 years old, was designed for a much smaller student body and residency staff and now needs rehabilitation and expansion. Dr. Albin O. Kuhn, the Chancellor for the University of Maryland at Baltimore, supports long range plans for such improvement. Dean John Dennis of the Medical School and Mr. G. Bruce McFadden, Director of University of Maryland Hospital, have offered a modest increase in faculty within the constraints of a tight budget to serve not only expanding clinical services but also the increasing demands of medical education, i.e., both an increase in size of the medical school classes as well as heavier curriculum responsibilities in the psychologic and sociologic aspects of medicine. The new addition to Howard Hall expands the research facilities of the Department. All of this bodes well for the future.

However, there are some ominous signs on the horizon. In the past six years due to cutbacks in federal funding, the Department has lost over $750,000 in research and teaching support from non-University sources, with only a relatively modest increase in the University budget to compensate for this loss. The University of Maryland Hospital is being forced into "fiscal responsibility," which means that administrators must seriously consider not only the teaching and research potential of a given service, but whether it will pay for itself. The faculty will become responsible for providing service that will augment Hospital income—with the inherent danger that this will interfere with their academic and research efforts. In meeting these needs there is the distinct possibility that we may regress to a pre-Flexnerian trade school attitude, although we hope to avoid this undesirable consequence.

The next ten years will also see drastic changes within medical practice, some initiated by the profession itself and others forced upon it by legislative fiat. These will have the laudable aim of assuring the right to essential health services for all citizens regardless of their economic resources. At this point, however, it is foolhardy to predict the nature of these changes or how successfully they will accomplish their stated goal. As chairman, I hope that not only I but also the Departmental faculty will lead rather than merely respond. I hope that we will accept the necessity for change as well as take risks in promoting innovation without discarding what has proven worthwhile in the past. We must not compromise in providing the most up-to-date, scientific, medical care. At the same time we must not use our "medical integrity" as a rationalization for resisting changes in health delivery systems.

There are six departmental programs which I believe will be necessary to meet the demands of the next decade. These programs are not written in stone, as I am sure they will be constantly revised as we proceed step-by-step on our course of modifying medical practice to meet the "right to the best possible medical care."

I. Continuing Education.

By tradition, experience, temperament and training, the faculty is equipped for its educational role. In the next decade, there will undoubtedly be an extension of requirements for continuing education already initiated by both medical licensing agencies and specialty boards, accompanied by some kind of evaluation of the practicing physician. An extensive continuing educational program, under the direction of a faculty member devoting full time to this enterprise and attuned to changes in attitudes and procedures regarding continuing education, will be an essential responsibility of any clinical department. This will be one of the most crucial functions of the Department in the immediate future.

II. Delivery of health care.

Although the Medical School has always been concerned with the excellence of its health care, it has inadvertently neglected to provide such excellence to some populations. It will be the responsibility of all clinical departments to explore new methods for health delivery and to teach techniques for comprehensive health care systems to the medical student. We will best accomplish this by assuming responsibility for the mental health problems of specified catchments, particularly population groups underprivileged with regard to health care services. In psychiatry this is reflected in community mental health programs for which the Department will be expected to assume increasing responsibility.

III. Distribution of health care services.

The Department must assume responsibility for the appropriate geographic distribution of psychiatrists who will provide such services in areas now deprived, particularly inner city and rural communities. At the same time, we must be certain that services are provided for high risk groups, such as the developing infant, the transitional adolescent, and the geriatric population. In cooperation with the Medical School's new program in Area Health Education Centers to be established in deprived and geographically isolated areas as well as for high risk groups, this becomes a cooperative endeavor with other clinical departments, particularly the Family Practice and Primary Physician Programs.

IV. Research

Despite the outstanding advances in our knowledge of psychoactive drugs, and the neurochemistry of the central nervous system, much of psychiatry remains an empirical science with unpredictable clinical results. The economic as well as humanistic aspects of mental illness will be overwhelming without new knowledge regarding their prevention, treatment, and rehabilitation.

It has been a traditional responsibility of the University to contribute new knowledge and no other responsibility should be considered primary to this. The recent addition of clinical laboratory facilities in the Howard Hall addition, plus the legislative enactment of an affiliation between the Maryland Psychiatric Research Center (heretofore an isolated research facility within the Department of Health and Mental Hygiene) and the Department of Psychiatry should facilitate Maryland's contribution to this new knowledge as well as attract funds from within and without the state to support research on the behavioral disorders.

V. Efficient use of available resources.

The escalating cost of medical care demands the efficient use of already established resources not only

for teaching and research but also for service. The Department is dedicated to developing a closer liaison with the Veterans Administration and the Division of Mental Hygiene and Drug Addiction, as well as the community hospitals. We cannot afford a parochial elitism in this era of economic constraints.

VI. The training of paraprofessionals.

Although the Medical School has devoted its total educational energy toward the M.D. and the post-M.D. degree, this is fast becoming an extravagance which cannot be continued. The proper delivery of medical care depends upon professionals, not only at the doctoral level (e.g. clinical psychologists) or at the traditional predoctoral level (Masters of Social Work) but must also include specific counseling and therapeutic services including marital counselors, sex therapists, mental health aides, psychiatric nurses, etc., all of whom can provide competent therapeutic services for the behavioral disorders under the direction of physicians trained in the behavioral sciences. Clinics which provide experience in these areas, plus educational programs which meet the needs of state certification agencies as well as national specialty organizations, must be provided by the University. Otherwise, training experiences will be "bootlegged" under less auspicious circumstances.

If all this seems to neglect the educations of medical students and residents or the clinical services to University Hospital, it is only because these are already well-established models to be emulated by developing medical schools. It will be our responsibility to be sure that these established programs evolve with the times and do not become rigidly bound by traditions or negligence of new advances in the behavioral sciences.

It is obvious then that the Chairman of the Department of Psychiatry will have responsibilities which transcend his duties as Director of the Institute of Psychiatry and Human Behavior. Fortunately, the Institute is a mature organization which already has a tradition and reputation for competence. The current faculty will be able to maintain this competence. The Chairman's job will be directed outside the Institute itself to an increasing degree.

I hope that in these endeavors I can do as well for my successor as my predecessors have done for me.

ALUMNI BULLETIN REPORT:

Institute of Psychiatry and Human Behavior

The aims and functions of the Department of Psychiatry at the University of Maryland School of Medicine are those of clinical departments and medical schools throughout the nation. They include the education of professional personnel, particularly medical students and physician specialists; production of new knowledge without which the health care delivery system would have little to deliver; and the maintenance of clinical services necessary to achieve the first two aims. The central educational, research and service unit of the Department of Psychiatry is the Institute of Psychiatry and Human Behavior. It is the aim of this article to highlight the services which are provided for patient care.

Adult Inpatient Service

This service comprises four wards of approximately 16 beds apiece, each functioning semi-autonomously. All of the adult wards have a basic commitment to dynamic psychotherapy and milieu therapy. At the same time, each ward has developed differentiating features which produce diversity in specific treatment modalities such as family therapy, psychopharmacology, and psychodrama. There is a pragmatic application of the present levels of psychiatric knowledge focused on rehabilitation and what will be useful to the patient in post-hospital life.

The Adult Inpatient Division offers treatment of a variety of psychiatric conditions. There are approximately 510 admissions per year. Some patients remain only a few days, others are hospitalized for several months and the average length of stay is 40 days. Adolescents compromise about 12 percent of the patient population. For these young patients, in addition to a regular program of individual, group and milieu therapy, there is a fully-accredited, full-time school program staffed by teachers assigned from the Baltimore City Board of Education. There is no loss of continuity of the students' education because of hospitalization.

The Adult Inpatient Division is supported by a large attending staff who bring with them an extensive and varied clinical experience. This means that various treatment modalities can be implemented. Of course, the total diagnostic services of the University Hospital are available.

In July of 1975, a family study center was created on one of the inpatient units. The purpose of this ward is to provide intensive evaluation and treatment for hospitalized patients and their families. Each inpatient has an extensive family history and evaluation done and most families are seen in weekly family therapy as well as in a multifamily group. This ward provides a locus for the training of residents, medical students, nurses, social work students, etc. in the skills of recognizing family dynamics and in the implementation of effective family therapy.

Among the numerous treatment modalities utilized during inpatient treatment, an important aspect is that of the Activity Therapy Department. The activity therapy approach deals with the interaction and interpersonal relationships with the whole patient group and the staff. In this program, activities are fostered to help establish independence and prepare the patient to return to his own community. The patient has a role in preparing his own therapeutic program and making plans for his future.

The Adult Inpatient Division accepts patients aged 13 and up. All patients must be admitted on a voluntary basis. Patients are admitted as quickly as possible, but because of the many referrals there is often a waiting list. There are no geographic limitations: patients are referred from all over Maryland as well as nearby states.

The daily hospital charge for all patients on the Adult Inpatient Division is $177 per day. Financial arrangements must be definite at the time of admission. There are financial counselors available to help advise about third party coverage.

The Chief Resident of the Adult Inpatient Division receives all requests for admissions from 8:30 a.m. to 4:30 p.m., Monday through Friday. The Chief Resident can be reached at 528-6649. On weekends and after 4:30 p.m., the resident on call handles requests for emergency admissions only.

Children's Residential Treatment Service

The Children's Residential Treatment Service provides comprehensive long-term treatment for severely disturbed latency-aged children and their families, as well as training for specialists from a variety of allied health programs. All children return to their families' homes each weekend in order to enhance the child-rearing mission of the parents. Consequently, work with families is as intensive as that with the child himself. Preadmission and extended follow-up by the service provide for a continuity of care. Day-patient status is also used for children of families when child-rearing strengths are consistently demonstrated at home. Generally, children are not admitted to this program unless other methods of intervention have been exhausted. A proscriptive education program is provided by staff qualified in special education. The Children's Residential Service is viewed throughout this region as a unique program because of the clinical and socio-economic range of children served as well as the variety of therapeutic modalities intensively employed in concert. Inquiries about admission and referrals to the service may be obtained by telphoning 528-6392.

Child and Adolescent Psychiatry Clinic

The Child and Adolescent Psychiatry Clinic meets training needs of general psychiatrists, child psychiatrists, psychologists, social workers, child psychiatry nurses, and other mental health and medical professionals. The clinic has an equal commitment to provide quality mental health service to children, adolescents, and families in the community.

Clinical experience here helps mental health trainees in mastering diagnostic and treatment skills in working with children, adolescents and their families, and gives them a more integrated understanding of the relationship of childhood experiences, including the theories of normal and pathological development. Evaluating and treating children enable the mental health trainee to gain a better appreciation of the forces on the child's genetic endowment and coping ability, the family, and the social system in supporting or crippling the child's psycho-social growth and the eventual development of the adult personality. Psychiatrists, psychologists, social workers, and nurses in the clinic assess the strengths and weakness of the child and his support systems, and intervene by working directly with the child, family, school, church, or any other persons or institutions which significantly contribute to the child's development. The faculty, which provides supervision, consultation, and support to the trainees, consists of psychiatrists, pediatricians, a neurologist, child psychologist, child psychiatry nurse, psychiatric social worker, and special education teachers.

The Clinic provides mental health services to children and adolescents ages 2-17 and their families. Services offered are evaluation, consultation, brief or long-term therapy, group therapy, and family therapy. Children, adolescents, and their families are referred from many sources: schools, pediatricians, psychiatrists, social workers, etc., as well as parents on their own initiative contacting us for help with their child. In order to make referrals to the Clinic, prior telephone contact is necessary at 528-6391 or 528-6822. The caller should request to speak with the professional on duty that day to discuss requests for the clinic's services.

The Central Maryland SIDS (Sudden Infant Death Syndrome or Crib Death) Center is administered by our Division of Child and Adolescent Psychiatry and has collaboration from the Department of Pediatrics, the Medical Examiners Office, and the Guild for Infant Survival. The goals of this project are to offer counseling services to all families experiencing such a loss within the shortest period of time following the death, to coordinate the various agencies and services that come in contact with the family, and to provide education and information about SIDS to the general public, physicians, clergy, policemen, nurses, medical examiners, funeral directors and emergency medical teams. Inquiries for consultation and counseling should be made from Project Director at 528-6935.

Adult Ambulatory Care

Adult Ambulatory Care at the Institute of Psychiatry and Human Behavior is comprised of several clinics that offer a full range of outpatient care from acute crisis intervention to psychoanalytically-oriented psychotherapy, group psychotherapy, and family therapy. The clinics are coordinated such that continuity of care is maximized. This full range of psychiatric service is a fundamental part of the training program at all levels. These clinics are described below.

Brief Therapy Clinic

The Brief Therapy Clinic is an outpatient facility which provides crisis-intervention and/or time-limited supportive psychotherapy for a multitude of patients. These patients primarily come from the inner-city area. Open Clinic is the major referring source, with the Medical Clinics as the second major referral source. The patients are seen on a weekly basis by junior and senior medical students and Family Practice residents. Treatment is at least six weeks in length. Patients are continued in the clinic or referred to another facility if further care is needed when their doctors end their psychiatric rotation. We accept a very wide range of patients—from 16 years through geriatrics—and with many different types of psychopathology. Referrals can be made by calling 528-6969.

Intensive Psychotherapy Clinic

Insight psychotherapy, including psychoanalysis, is offered to patients who fulfill the criteria for these forms of therapy. The primary criteria are the patient's capacities for introspection and motivation for this form of therapy. Medications may or may not be used. It is felt that intensive psychotherapy is the basic element in outpatient psychiatry from which other techniques are derived. The minimal activity of the therapist in this technique permits the patient to clarify problems in living, and provides maximum respect for the patient's autonomy. Referrals to the Intensive Psychotherapy Clinic may be made by contacting the Outpatient Chief Resident at 528-6344.

Group Therapy Clinic

Group therapy offers patients an opportunity to share experiences with other patients and to develop interpersonal skills. It is reassuring to patients to realize that their problems in living are not unique. The orientations represented in the group psychotherapy clinic include those of the Tavistock Clinic, the National Training Laboratories, and that of traditional group psychotherapy. Referrals to group therapy may be made by contacting the Outpatient Chief Resident at 528-6344.

Open Clinic

The primary task of this clinic is the rapid evaluation and, where appropriate, rapid resolution of an emotional crisis. Although no appointment is necessary, a telephone call prior to coming to the clinic is helpful. If a rapid resolution is not possible, an appropriate referral is made.

The clinic serves as a training ground for psychiatric residents, family practice residents, graduate students in social work, medical students, and occasionally graduate students from a number of other disciplines. While the emphasis may vary among disciplines, in

general trainees are taught principles of crisis intervention, differential diagnoses and crisis interviewing. Supervision is provided by senior faculty psychiatrists and the director of the clinic, and by social workers and psychiatric nurses who staff the clinic. Referral can be made to the clinic by telephoning 528-6560/6561.

Continuing Treatment Clinic

This clinic provides outpatient psychopharmacologic therapy for patients who require maintenance medication. These include the schizophrenic, manic-depressive, depressive and geriatric patients. Supportive psychotherapy is provided, but generally visits last 15 to 20 minutes, and the interval between visits may vary from one week to six months. Patients must have already had diagnostic workup and a preliminary medical regimen established before referral. The clinic provides consultative services to the medical-surgical clinics in the selection and prescription of tranquilizing agents.

Resident training in the clinic includes patient care and weekly conferences reviewing basic neurochemistry and progress in psychopharmacology. Further information about referral can be obtained by calling the clinic at 528-6875.

Family Therapy Clinic

This clinic provides an evaluation and treatment program for families and couples, preferably without a designated patient. Families requiring a backup of community and social services are generally referred to family service agencies better equipped to provide for the ongoing family members. Otherwise, there are no eligibility or geographic restrictions and the clinic operates on a sliding fee scale.

The Family Therapy Clinic provides short-term treatment in response to maturational or situational crisis, as well as long-term treatment where indicated. Weekly therapy sessions are the norm. The clinic is equipped to handle a variety of family-related problems, including marital conflict and sexual dysfunction and emotional and behavioral disorders. All family therapists receive faculty supervision which may include the use of a one-way mirror and/or videotape.

Referrals to the Family Therapy Clinic are accepted from within the University Hospital system and also from the general community, including physicians, clergy and other professional or community agency sources, as well as self-referrals. The clinic is also a referral source for the families of patients discharged from our inpatient service requiring ongoing family therapy. Families are seen by appointment only. Referrals and further information can be made by telephoning the clinic at 528-6767.

Violence Clinic

The Clinical Program for Violent Behavior was instituted to evaluate and treat patients with aggressive propensities. Since its inception, the clinic has seen approximately 500 patients, either self- or agency-referred. The philosophy and structure of the clinic have been described in numerous professional journals and the clinic has served as a model for diagnostic evaluations and treatment of a group of patients ordinarily shunned by the medical profession.

The emphasis in the clinic has been two-fold. First, it has been our interest to evaluate traditional psychodynamic factors which precipitate or provoke rage attacks and temper outbursts in these patients who are so sensitive to such issues as maternal abandonment or insults to masculinity or self-esteem. Second, we have been interested in assessing those organic factors which contribute to the poor control of hostile impulses and the paroxysmal and labile expression of anger and impulsivity. Comprehensive psychological testing for organicity, special electroencephalographic procedures, and neurologic consultation are features which help to diagnose cases of brain dysfunction in children, adolescents, and adults.

Individual and group psychotherapy are active modalities of treatment and several ongoing groups are available to patients who wish help for the control of aggression and violence. The identification and treatment of victims has become an important part of the therapeutic strategy. Innovative treatment techniques involving the elaboration of fantasy and the experiencing of affect are important modalities of therapy for this group of impulsive aggressive patients.

The clinic has been active in seeing selected cases of child battering, wife abuse, and alcohol-related violence, and has been active in social policy issues involving imprisonment, the role of the media in depicting violence, and the role brain dysfunction plays in violent behavior.

Consultation to local and distant medical facilities has been an important function of the clinic. A limited number of residents and students each year elect to rotate through the clinic and to gain experience in the management of violent patients. Referrals to the clinic may be made by calling the Director of the Clinic at 528-6475.

Psychosomatic Clinics

The Psychosomatic Clinics offer a variety of specialized diagnostic and therapeutic services. These services are open to patients with various pain syndromes, obesity, and a variety of sleep disorders. The intent of the Psychosomatic Clinics is threefold: (1) to provide services to patients who might benefit from some of the new specialized treatments such as biofeedback; (2) to evolve new approaches to psychosomatic complaints based on psychophysiologic observations, and (3) to provide edu-

cation and training in specialized psychosomatic therapies to interested students, residents, staff and outside professionals.

The clinics are staffed by a psychiatrist who acts as medical director, and two psychologists who are trained in huxan psychophysiology and psychophysiological instrumentation. If a patient is judged amenable to treatment by one of these approaches of the clinics, suitable schedule of treatment is arranged and the patient's status is reviewed weekly, in a meeting of the entire staff, where adjustments in the regimen are discussed.

The associated Psychophysiological Laboratories are involved in ongoing projects in the University of Maryland Hospital Coronary Care Unit assessing the psychological and physiological factors influencing cardiac arrhythmias. During the past year these studies have focused on sleep patterns in the Coronary Care Unit and their influence on cardiac arrhythmias. Referral to the Psychosomatic Clinics may be made by telephoning 528-6644.

Hypnotherapy Clinic

The Hypnotherapy Clinic provides the opportunity for medical students and residents who have completed the basic course in hypnosis to gain experience in the use of hypnosis as a treatment modality. A wide range of patients allows for a varied experience including such areas as pain control, smoking control, psychosomatic illness, conversion symptoms, phobias, etc. Supervision is also available for hypnotic techniques in uncovering therapies. Experience in hypnotic therapies will be available for residents from a variety of specialities since hypnosis is a useful treatment modality in many types of illness. Supervision is provided depending on the degree of experience of the trainee.

The clinic provides a service generally unavailable in the past. Although hypnotic therapy has been available on a limited basis for private patients, it has been essentially unavailable otherwise. Patients are charged on a sliding scale based on their gross income. Patients may be referred to the clinic by telephoning the Director of the Clinic at 528-6790.

Clinical Services: Alcohol and Drug Abuse

Tuerk House is a residential facility located at 106 N. Greene Street. It provides male alcoholics with detoxification and environmental treatment. The men who are admitted have to be ambulatory and not in need of hospitalization for either severe medical or psychiatric treatment. Medical screening is usually done in the emergency room of University Hospital and is required before admission. For admission or information contact: 539-6025.

The Alpha House at 829 N. Eutaw Street is a similar facility for women, with the same criteria for admission. For admission or information contact: 523-2626.

There are numerous individual and group therapy outpatient activities available, not only during working hours but also evenings and weekends. For information contact: 528-6800 (01) (03).

The Alcohol and Drug Abuse Program also operates the Families and Children's Clinic. This clinic is a research and demonstration project funded by the National Institute of Alcoholism and Alcohol Abuse to explore the treatment potentials of family systems therapy with those families whose dysfunction includes a problem of alcoholism in a parent and a behavior problem in a child. The referral procedure at the present time is to evaluate those families whose explicit concern is for the child's problem. The criteria for referred families are: families with two or more children of school age, one of whom has a behavioral problem, and one or more adults either alcoholic or with a drinking problem. Referrals can be made by telephoning 528-5157.

The Methadone Maintenance Treatment Program which is located at 104 North Greene Street will accept patients for methadone maintenance according to Federal and State guidelines. For information contact: 837-3313.

Liaison Psychiatry

The Division of Liaison Psychiatry has as its principle foci teaching and research related to the interface of medicine and psychiatry. The aim of this program is not only to familiarize medical students, residents, medical staff and paramedical personnel with the theoretical principles and clinical application of psychosomatic medicine, but also to foster a holistic perspective with regard to the patient and his overall medical management.

Clinical instruction and research are accomplished within the framework of an on-going consultative service. The Division maintains an active consultation program for both ward and private patients of all departments and divisions within the University of Maryland Hospital. Under the supervision of the senior staff

of the Division, psychiatric residents on the second year level spend six months acting as primary consultants in psychiatry to assigned areas within the general hospital and its outpatient facilities. In addition to direct patient evaluation and treatment, regular consultative teaching rounds are offered for medical and paramedical staff in many of the areas served.

An intensive educational program has been carried on in cooperation with the Department of Family Practice over the past four years. The Division has been responsible for the development and administration of a program consisting of specially tailored didactic and clinical instruction relevant to the needs of the emerging speciality of Family Practice. Continuing research into and evaluation of the unique psychiatric expertise required by the primary care physician constitute a major thrust of the Division.

Other areas of current interest include the development of special techniques in the evaluation and treatment of psychophysiologic disorders and the study of the emotional response to and effects of specific disease entities including severe trauma, chronic renal failure, and spine injury. Patient referrals, as well as requests for information and non-patient consultation may be directed to the Division's Office at 528-6090.

Student Mental Health Service

The Student Health Service provides psychiatric consultation to students from the Baltimore Campus. The services provided are primarily crisis intervention, evaluation, and brief psychotherapy, limited to approximately ten hours.

The Student Health Service offers an excellent training opportunity for advanced residents. In addition to the evaluating and referring of students, the resident treats many students in brief psychotherapy. Because of the nature of the presenting problems, and the high motivation and general adaptive capacity of the students, many of the students are good candidates for brief psychotherapy. A number of students are also referred to the Outpatient Clinic where residents treat them in long-term intensive psychotherapy. Student referrals or inquiries may be made at the Baltimore City Campus by calling 528-6790.

The University of Maryland Baltimore County Health Service, while an independent agency, is affiliated with the Department of Psychiatry. The Psychiatric Service provides evaluation, brief therapy, group therapy, and long-term therapy to the students of the University of Maryland Baltimore County Campus. Treatment is provided by a staff psychiatrist, psychiatric residents, and advanced medical students who elect to see long-term patients in dynamic psychotherapy at the health facility.

Referrals and treatment are limited to those students who are registered at the campus in Baltimore County. Referrals may be made through the Student Health Service at that campus by calling 455-2542.

Sexual Dysfunction Clinic

This Clinic provides diagnoses and treatment for disorders of the sexual response. Referrals are accepted from physicians and community agencies for evaluation. About half of the patients referred are felt to be suitable for therapy in this clinic, that is, they have primary sexual problems or sexual dysfunction secondary to disturbed interpersonal relationships.

Starting in June, 1977, the Clinic will offer a training program in collaboration with the American Association of Sex Educators, Counselors and Therapists. This program will serve as a model for the training of not only physicians but other health care professionals. Referrals can be made by calling 528-6636.

Psychiatric Associates

The geographic full-time medical faculty of the department, under guidelines of the medical practice regulations of the University, have incorporated and offer private psychiatric consultation and treatment services. Patients are largely, but not exclusively, outpatients and are seen by appointment only in the faculty member's office. Fees are those charged by the psychiatric profession in the community. Twenty-two of the faculty are members of the corporation and offer a wide range of expertise. If the referring physician or agency has identified a patient with special problems, telephone consultation with the Director of the Institute will assure a proper referral to a member of the corporation. If the expertise is not available among corporate members, the referral will be made to an appropriate professional within the community. For referral call 528-6735, between 8:30 a.m.-4:30 p.m., Monday through Friday.

A Word about Fees for Patient Service

As previously mentioned in several of our service descriptions, most outpatient fees for service are based on a sliding fee scale determined by the patient's gross income. This fee scale is determined by state's statute and is not under the control of the Department of Psychiatry. There is no sliding fee scale for inpatient treatment, although selected patients who are helpful for teaching purposes and who require hospitalization beyond third party coverage are maintained in the hospital rather than transferred to other state institutions.

Institute of Psychiatry & Human Behavior
Department of Psychiatry

Fulltime Faculty

Professors

BALIS, GEORGE U., M.D.
Director, Undergraduate Psychiatric Education
BRODY, EUGENE B., M.D.
Editor-in-Chief, Journal of Nervous & Mental Disease
FRIEDMAN, STANFORD B., M.D.
Director, Division of Child & Adolescent Psychiatry
GRENELL, ROBERT G., Ph.D.
Director, Neurobiology Laboratories
HUFFER, VIRGINIA, M.D.
Director, Division of Liaison Psychiatry
LYNCH, JAMES J., Ph.D.
Director, Behavioral Laboratories
MONROE, RUSSELL R., M.D.
Department Chairman & Director, Institute of Psychiatry & Human Behavior
WEINTRAUB, WALTER, M.D.
Director of Graduate Training
Associate Department Chairman

Associate Professors

BOSMA, WILLEM G.A., M.D.
Director, Division of Alcoholism & Addiction Services
DONNER, LAWRENCE
Clinical Psychology
GROSS, HERBERT S., M.D.
Associate Director, Institute of Psychiatry & Human Behavior
HUNT, GERARD J., Ph.D.
Medical Sociology
KAMBACK, MARVIN C., Ph.D.
Division of Alcoholism & Addiction Services
LION, JOHN R., M.D.
Director, Clinical Research for Violent Behavior
MACKIE, JAMES B., Ph.D.
Chief Psychologist
MODARRESSI, TAGHI M., M.D.
Division of Child & Adolescent Psychiatry
MOTT, THURMAN, Jr., M.D.
Director, Student Mental Health Services
PLAUT, S. MICHAEL, Ph.D.
Division of Child & Adolescent Psychiatry
SAKLES, CONSTANTINE J., M.D.
Director, Division of Adult Inpatient Psychiatry
SARLES, RICHARD M., M.D.
Director, Child Psychiatry-Pediatric Liaison Service
Division of Child & Adolescent Psychiatry
SCRATTON, JOAN M., M.S.W.
Director, Division of Psychiatric Social Work
Director, Family Clinic
WEIR, W. DOUGLAS, M.D.
Division of Liaison Psychiatry
Director of Continuing Education
WURMSER, LEON, M.D.
Division of Alcoholism & Addiction Services
Medical Director, Addictive Services

Assistant Professors

ALBRIGHT, MARY JO, Ph.D.
Clinical Psychology
Division of Child & Adolescent Psychiatry
ARANA, JOSE, M.D.
Administrator Unit 3G
Division of Adult Inpatient Psychiatry
AZCARATE, CARLOS, M.D.
Administrator Unit 3F
Division of Adult Inpatient Psychiatry
BRADFORD, NORMAN H., Ph.D.
Clinical Psychology
Division of Adult Inpatient Psychiatry
BROWN, ROBERT M., M.A.
Psychologist III (Classified)
COHEN, GEORGE M., M.Sc.
Director, Child Care
Division of Child & Adolescent Psychiatry
DONAHOE, KAY, M.S.W.
Senior Psychiatric Social Worker III (Classified)
FELICE, MARIANNE, M.D.
Division of Child & Adolescent Psychiatry
FREEDENBURG, DANIEL J., JR., M.D.
Division of Liaison Psychiatry
Director, Student Mental Health, UMBC
GALLAHORN, GEORGE E., M.D.
Director, Open Clinic
Division of Adult Ambulatory Care
HARBIN, HENRY T., M.D.
Administrator Unit 3F
Division of Adult Inpatient Psychiatry
HILL, WILLIAM B., M.Ed.
Division of Child & Adolescent Psychiatry
JANTZ, ELEANOR M., Ph.D.
Clinical Psychology
Division of Liaison Psychiatry
JONES, NORMA, M.S.W.
Open Clinic & Coordinator of Family Clinic
Division of Adult Ambulatory Care
KARAHASANOGLU, ALP, M.D.
Director, Children's Residential Service
Division of Child & Adolescent Psychiatry
KOHN-RABIN, NANCY, Ph.D.
Clinical Psychology
Division of Child & Adolescent Psychiatry
LEICHTMAN, SANDRA R., Ph.D.
Clinical Psychology
Division of Child & Adolescent Psychiatry
LEWIS, GAIL L., R.N., M.S.
Clinical Specialist II (Classified)
Division of Child & Adolescent Psychiatry
McDANIEL, ELLEN, M.D.
Director, Division of Adult Ambulatory Care
McLANEY, MARTHA, M.S.W.
Director of The Child & Adolescent Psychiatry Clinic
Division of Child & Adolescent Psychiatry
MANZANERA, ELENA, M.S.
Division of Alcoholism & Addiction Services
MURPHY, DOUGLAS, B.A.
Division of Alcoholism & Addiction Services
NOLAN, JAY H., Ph.D.
Medical Anthropology
PASKEWITZ, DAVID A., Ph.D.
Behavioral Laboratories
RODBELL, STANLEY L., M.S.W.
Director, Methadone Maintenance Treatment Program
Division of Alcoholism & Addiction Services
SATTERFIELD, SHARON, M.D.
Medical Director, Sexual Dysfunction Clinic
SCHREDER, RICHARD H., M.S.W.
Director, TV Studio's Program
Division of Psychiatric Social Work
WALLIS, KATHERINE D., R.N., M.S.
Director of Psychiatric Nursing
WEINSTEIN, STANLEY, M.S.W.
Psychiatric Social Work
Division of Child & Adolescent Psychiatry
Project Director, Central Maryland SIDS Center and Children's Residential Service
WOOLSEY, SUSAN F., M.S.
Division of Child & Adolescent Psychiatry

Instructors

BURKA, ADEN A., Ph.D.
Division of Child & Adolescent Psychiatry
CEPHAS, BARBARA J., M.S.W.
Division of Adult Inpatient Psychiatry, Unit 2G
FITCH, FRANCES J., M.S.
Division of Alcoholism & Addiction Services
GOODBODY, SANDRA T., M.S.W.
Children's Residential Service
Division of Child & Adolescent Psychiatry
MATERS, WENDY P., R.N.
Division of Alcoholism & Addiction Services
O'DONNELL, JAMES J.
Division of Alcoholism & Addiction Services
ROOP, ANN B., M.S.W.
Director of Counselling Central Maryland SIDS Program
Division of Child & Adolescent Psychiatry
SEMAN, PATTI, M.S.W.
Division of Adult Inpatient Psychiatry, Unit 3G
VAULS, KERSLEY, B.A.
Director, Activity Therapies

Research Associates

EINBERG, ELMAR, E.E.
Neurobiology, Laboratories
McCULLOCH, DUNCAN, E.E.
Neurobiology Laboratories
WAX, TEENA, Ph.D.
Division of Child & Adolescent Psychiatry

Research Assistants

GLASNER, DOROTHY, M.A.
Accelerated Training Program, part-time
RUBIN, JEFFREY, B.A.
Brain—Behavior Project

Part-Time Faculty

Professors

BENDER, LAURETTA, M.D.
Division of Child & Adolescent Psychiatry
BARTEMEIER, LEO, M.D.

GANTT, W. HORSLEY, M.D.
Behavioral Laboratories
HALEY, JAY D., M.A.
Division of Graduate Training
LISANSKY, EPHRAIM T., M.D.
Professor of Internal Medicine
SAVAGE, CHARLES, M.D.
Chief, Psychiatry, VA Hospital, Loch Raven
SCHNAPER, NATHAN, M.D.
Graduate & Undergraduate Psychiatric Education
SIEGMAN, ARON W., Ph.D.
Chairman, Dept. of Psychology UMBC

Associate Professors

ASCHER, EDUARD, M.D.
Consultant, Group Therapy
CLEMMENS, RAYMOND L., M.D.
Pediatric Consultant, Division of Child & Adolescent Psychiatry
DAVID, HENRY P., Ph.D.
Consultant, International & Family Planning
GLASER, KURT, M.D.
Division of Child & Adolescent Psychiatry
GIBSON, ROBERT W., M.D.
Medical Director, Sheppard & Enoch Pratt Hospital
GODEENE, GHISLAINE, M.D.
Division of Child & Adolescent Psychiatry
GRAY, SHEILA HAFTER, M.D.
Division of Adult Ambulatory Care
HOLDEN, WILLIAM, M.D.
Division of Adult Ambulatory Care
KOHLMEYER, WERNER, M.D.
Inner City Community Mental Health Center
NEWMAN, RUTH G., Ph.D.
Clinical Psychology, Director, Program in Group Psychotherapy
PANDE, SHASHI KUMAR, M.D.
Division of Undergraduate Training
RAPPEPORT, JONAS R., M.D.
Chief Medical Consultant, Supreme Bench of Baltimore
ROSEMAN, MORRIS, Ph.D.
Clinical Psychology (School of Dentistry)
SHOCHET, BERNARD, M.D.
Undergraduate Education
STYRT, JEROME, M.D.
Division of Adult Ambulatory Care
TUERK, ISADORE, M.D.
Division of Adult Ambulatory Care
VEIGA, MARIANO, M.D.
Division of Child & Adolescent Psychiatry

Assistant Professors

ARMSTRONG, JUDITH, Ph.D.
Clinical Psychology
Division of Child & Adolescent Psychiatry
BACHER, NORMAN M., M.D.
Division of Adult Ambulatory Care
BARCIK, J. DAVID, Ph.D.
Clinical Psychology
BARRY, RONALD M., M.D.
Division of Child & Adolescent Psychiatry
BERAN, BOHUMIL F., M.D.
Graduate Education
BROWN, GEORGE P., M.D.

CARNEY, FRANCIS L., JR., Ph.D.
Special Offender's Clinic
CHABON, ROBERT, M.D.
Division of Child & Adolescent Psychiatry
CHAIKLIN, HARRIS, Ph.D., M.S.
Division of Psychiatric Social Work
COHEN, SYDNEY, M.D.
Division of Child & Adolescent Psychiatry
COHEN, IRVIN H., M.D.
Sheppard & Enoch Pratt Hospital
COLEMAN, PETER J., M.D.
Division of Child & Adolescent Psychiatry
DASHEF, STEPHEN S., M.D.
Division of Adult Ambulatory Care
DAVIS, NATHAN, M.D.
Division of Adult Ambulatory Care
DIXON, WILLIAM, M.D.
Sheppard & Enoch Pratt Hospital
DUBIN, SAMUEL, M.D.
Division of Adult Ambulatory Care
FIEDLER, KURT, M.D.
FELICE, MARIANNE, M.D.
Division of Child and Adolescent Psychiatry

FITZPATRICK, WILLIAM W., M.D.

FRIEMAN, ROBERT D., M.F.
Division of Adult Ambulatory Care
GAVIN, ARLENE, M.S.W.
Division of Psychiatric Social Work
GORDON, BERNARD S., M.D.
Division of Adult Ambulatory Care

Assistant Professors Cont'd

GOSHEN, ROBERT, M.D.
Division of Child & Adolescent Psychiatry
GRAHAM, DAVID B., M.D.
Division of Child & Adolescent Psychiatry
HARAN, JUDY E., M.S.W.
Director, Lindale Learning Disabilities Clinic
Division of Child & Adolescent Psychiatry
HARRIS, ROGER C., M.D.
Division of Adult Ambulatory Care
HERTS, JOHN B., M.D.
Clinical Research for Violent Behavior
HOLDER, W. LEWIS, M.D.
Division of Child & Adolescent Psychiatry
HULFISH, BARBARA, M.D.
Neurology in Psychiatry
ISEN, ALICE M., Ph.D.
Division of Child & Adolescent Psychiatry
JENCKS, STEPHEN F., M.D.
Division of Adult Ambulatory Care
JOHNSTON, DANIEL F., M.D.

KAISER, THEODORE, M.D.
Division of Child & Adolescent Psychiatry
KEMP, KATHERINE, M.D.

KENNY, THOMAS J., Ph.D.
Clinical Psychology
Division of Child & Adolescent Psychiatry
LAUCKS, S. PHILIP, M.D.

LEWIS, HARVEY A., M.D.
Division of Adult Ambulatory Care
LLOYD, DEE N., Ph.D.
Clinical Psychology
Psychiatric Education
LONG, S. EUGENE, M.D.
Community Mental Health Services
LONG, KATHLEEN, R.N., M.S.
Division of Child & Adolescent Psychiatry
LUCCO, ALFRED A., Ph.D.
Division of Psychiatric Social Work
LYNCH, THOMAS, M.D.

MAGRUDER, WILLIAM W., M.D.
Division of Adult Ambulatory Care
MAY, GERALD G., M.D.

MAXWELL, ANABEL, M.S.W.
Division of Child & Adolescent Psychiatry
MADDEN, DENIS J., Ph.D.
Clinical Research for Violent Behavior
McDONALD, MATHEW J., Ph.D.
Clinical Research
MOURAT, STEPHEN, M.D.
Division of Child & Adolescent Psychiatry
McAFFEE, LAURICE L., M.D.
Division of Child & Adolescent Psychiatry
McELROY, EVELYN M., Ph.D.
Division of Child & Adolescent Psychiatry
NOSHPITZ, JOSEPH D., M.D.
Division of Child & Adolescent Psychiatry
NYMAN, GARY W., M.D.
Director, Mental Hygiene Administration, DHMH
OLEYNICK, A. HARRY, M.D.
Neurology in Psychiatry
OLSEN, ROGER LEE, Ph.D.
Division of Child & Adolescent Psychiatry
OLSSON, JAMES E., Ph.D.
Clinical Psychology
Special Offender's Clinic
OZER, MARK M., M.D.
Neurology in Psychiatry
POWELL, ALBERT M., JR., M.D.
Division of Child & Adolescent Psychiatry
PRESS, LEONARD, MSSA
Division of Psychiatric Social Work

Instructors

ABBAS, MAHMOUD F., M.D.
Spring Grove State Hospital
ANDERSON, RICHARD H., M.D.

ARBOGAST, RICHARD C., M.D.
Psychiatry & Family Practice
ARNOLD, WILLIAM H., M.D.

BERGMANN, BARBARA, M.D.

BERMAN, MERRILL I., M.D.
Division of Child & Adolescent Psychiatry
BISCO, MICHAEL J., M.D.
Division of Adult Ambulatory Care
BURKA, ADEN A., Ph.D.
Division of Child & Adolescent Psychiatry
CHRISTOPHER, RUSSELL LEE, Jr., M.D.

CONNOR, HUELL E., Jr., M.D.

CROCE, GIOVANNI C., M.D.
Patuxent Institute
DECKER, CURTIS L., J.D.
Division of Child & Adolescent Psychiatry
DVOSKIN, PHILLIP, M.D.
Undergraduate Psychiatric Education
ELBESHIR, ABDEL M., M.D.
Undergraduate Psychiatric Education
FINN, ROLFE B., M.D.
Sheppard & Enoch Pratt Hospital
FLAHERTY, LOIS T., M.D.
Behavioral Laboratories
FLASHMAN, ALBERTA A., M.D.
Graduate Training
FREINEK, WILFRIED R., M.D.

GENUT, KATE L., M.S.W.
Open Clinic
Division of Adult Ambulatory Care
HAMILTON, JOHN, M.D.
Superintendent
Clifton T. Perkins Hospital
JOHNSON, FRANK P.
Undergraduate Psychiatric Education
KNIFFIN, LYNN, M.S.W.
Brief Therapy Clinic & Family Clinic
Division of Adult Ambulatory Care
LEVIN, LEON A., M.D.

LISANSKY, SYLVIA, M.S.W.
Division of Psychiatric Social Work
LEVY, STEVEN M., Ph.D.
Loch Raven VA Hospital
LOVE, LOIS H., M.D.
Graduate Training
REED, JULIAN W., M.D.
Associate Professor of Preventive Medicine
RHEAD, JOHN C., Ph.D.
Maryland Psychiatric Research Center
ROBINSON, LISA, Ph.D.
Psychiatric Nursing
Associate Professor, School of Nursing
ROBINSON, KENT E., M.D.
Sheppard & Enoch Pratt Hospital
ROMERO, EDUARDO, M.D.
Neurobiology Laboratories
SCHONFIELD, JACOB, Ph.D.
Clinical Psychology
Research Consultant
SCHWARTZ, LLOYD, Ph.D.
Spring Grove State Hospital
SCHWEIG, NOEL, M.D.
Division of Adult Ambulatory Care
SCHAPIRO, SOLOMON, Ph.D.
Clinical Psychology
Graduate Training
SHEAR, HOWARD J., Ph.D.
Clinical Psychology
Division of Adult Ambulatory Care
SILA, BASRI, M.D.
Division of Child & Adolescent Psychiatry
SOJIT, CLOE M.
Division of Alcoholism & Addiction Services
TORMEY, JUDITH, Ph.D.
Humanistic Studies
TUREK, IBRAHIM S., M.D.

ULGUR, ULKA, M.D.
Division of Child & Adolescent Psychiatry
VON MUEHLEN, LUTZ, M.D.
Undergraduate Psychiatric Education
WAIN, HAROLD J., Ph.D.

WEISMAN, MAXWELL N., M.D.
Director of Alcoholism, DHMH

MAZIAR, HOWARD M., M.D.
Division of Adult Ambulatory Care
OPPENHEIMER, RUTH, B.A.
Division of Child & Adolescent Psychiatry
POMERANTZ, GAIL, M.S.
Open Clinic
ROBERTS, RANDY, Ph.D.
Clinical Psychology
Graduate Training
RUDNICK, BARRY F., M.D.
Division of Adult Ambulatory Care
SAUNDERS, STEPHEN W., M.D.
Undergraduate Psychiatric Education
SCHULZ, CLARENCE G., M.D.
Sheppard & Enoch Pratt Hospital
SMITH, BOYLSTON D., M.D.
Special Offender's Clinic
SMITH, JAMES, II, M.D.
Special Offender's Clinic
STEINBACH, IRVIN L., M.A.
Clinical Psychology
Special Offender's Clinic
TAYLOR, RONALD J., M.D.
Assistant Chief, Psychiatry, VA Hospital Loch Raven
TERRY, JANE, M.D.
Graduate Education
TRATTNER, ROBERT E., M.D.

WARWICK, ARTHUR M., M.D.
Undergraduate Educational Program
WEINSTEIN, GERALD E., M.D.
Division of Child & Adolescent Psychiatry
WEINSTOCK, JOSEPH S., M.D.

WISE, SAMUEL P., III, M.D.
Eastern Shore State Hospital

Associates & Consultants

HARRIS, WILLIAM, M.D.
Division of Adult Inpatient Services, Unit 3F
MARSHALL, CURTIS, M.D.
Clinical Research
SIDHU, AJAIB D., M.D.
Division of Methadone Maintenance Treatment Program

Lecturers

KRAMER, MORTON, SC.D.

KURLAND, ALBERT A., M.D.
Maryland Psychiatric Research Center

PRESIDENT'S MESSAGE

James A. Roberts, M.D.

Hello again,

I will start off by giving you some very important dates, some or all of which whould be given top priority and set aside in your appointment book now because the 1977 book is already out. It really pays to plan early.

1. Bicentennial Celebration, Davidge Hall, Monday and Tuesday, December 6 and 7, 1976.

2. ALUMNI DAY, Hunt Valley and Davidge Hall, Wednesday and Thursday, June 1 and 2, 1977.

Also, any day you happen to be in Baltimore and want to browse around the Medical School area, why not make a walking tour and stop in at the Alumni Office on the second floor of Davidge Hall?

The Medical Alumni Association recently mailed over 5,000 *Bulletins* of the University of Maryland School of Medicine—one to each living alumnus of the Medical School, whether he is an "active" (i.e. dues paying) or "inactive" member. Your Board of Directors voted in favor of this because they felt all alumni should be equally informed. However, the annual cost of *The Bulletin* is divided between the Medical Alumni Association and the School of Medicine to the tune of approximately $7,500 each. Under this arrangement, I feel the Medical Alumni Association should become intimately involved in policy-making, input of materials, editorial policy, etc., because the *Bulletin* should be a major mode of communication between the Board in Baltimore and each alumnus, wherever he may be. We of the Board would appreciate any thoughts you may have about *The Bulletin,* or, for that matter, any affairs of the Association. However, I am sure your voice will be heard much clearer if you send your $20 for dues, if you have not already done so. You can well understand that we need many twenty-dollar bills to carry the increasing financial load of the Association as we grow and attempt bigger and better projects. So please, do me a favor, look through the current *Bulletin,* then take a few minutes and send your check for dues.

On July 1, 1976, the restoration of Davidge Hall began in earnest with a projected four-month comprehensive survey including drawings, x-rays, photography, wall and ceiling openings, historical documentation, mechanical and structural engineer consultations, architectural consultations, paint and mortar analysis, etc. After the data are collected, a cost analysis will be formulated so that we will have some idea of the total cost of restoring Davidge Hall. Of course, another vital function of the Davidge Hall Committee is to decide how much can actually be done toward reproducing the original halls and still make it a functional, safe and comfortable structure worthy of its stature as a historic, cultural and architectural site. Dr. John A. Wagner is doing a commendable job as Chairman of the Davidge Hall Committee and will report elsewhere in this issue. Those of us involved in this endeavor find it to be more and more exciting as we learn more about the structure, and we hope our enthusiasm will rub off on all of you.

On September 10, 1976, Mrs. Jean D. Goral and I attended the Alumni Council meeting of the University of Maryland Alumni Association-International at College Park, Maryland, and spent the evening listening to reports from many different groups including Pharmacy, Dental, Law and "M" Club, etc. I enjoyed my first meeting and personally felt that our own Alumni Association was a member of a very large team which had the promotion of the University of Maryland first and foremost in its mind. I think it's essential that we have our full representation of three members of the Medical Alumni present at the three remaining meetings this year.

The Bicentennial Celebration to be held on December 6 and 7, 1976, under the joint sponsorship of the Medical School, Hospital, and Medical Alumni Association, will feature speakers, music, scientific sessions, historical talks, receptions and dinners. Please come if you can arrange it—I know you'll find it worthwhile.

So far I'm having fun serving as your President, but I may get axed for sounding off so much as the year unfolds.

Thanks for listening.

Program of Continuing Education Schedules Activities

As a follow-up to last issue's article on the School of Medicine's Program of Continuing Education, an expanded discussion of several programs sponsored by that office follows.

Visiting Professor Program—This program provides an opportunity for medical staff physicians in community hospitals throughout Maryland to participate in accredited continuing medical education designed specifically around their needs. It is beneficial not only to the physician because of its convenience but also to the hospital by assisting in assuring that the hospital facility continues to provide high quality medical care. This program is a logical complement to a hospital's medical audit activities which may identify educational needs. If you are interested in further information on this program or would like the location of the nearest participating hospital, contact the Program of Continuing Education.

Rounds and Conferences—A listing of rounds and conferences at the University of Maryland Hospital and its affiliates, certified for AMA Category 1 credit, has been developed. Copies may be obtained from the Program of Continuing Education upon request.

The above offerings are among the ongoing efforts of the Program. Below is a brief description of one of the one-day seminars and a listing of other upcoming courses sponsored by the Program:

Intensive Care of the Critically Ill Patient—November 12, 1976

An outstanding group of specialists will discuss major concepts and recent advances dealing with priorities of intensive care, acute respiratory insufficiency, cardiovascular monitoring, metabolism of the critically ill patient, and the role of the computer in intensive care. A partial list of faculty includes Dr. James Duke of the University of Texas Medical School, Houston; Dr. Ake Grenvik of the University of Pittsburgh School of Medicine; Dr. Herbert Hechtman, Boston University School of Medicine; and Dr. Rene L. Gelber of the University of Maryland (Dr. Gelber is the course director).

December, 1976
3-4 Alcohol and Drug Abuse
9 Orthopedics Day

January, 1977
22-23 Family Medicine Intensive Learning Weekend #1

February, 1977
5 Plastic Surgery Symposium
10 Symposium on Risk Reduction and Health Behavior
11 Gynecology Day
17-18 Burn Symposium
19 Traumatology
24-26 Dermatology Days
26 Symposium on Medical Audit and Peer Review

All activities of the Program of Continuing Education are accredited by the AMA for credit in Category 1 towards its "Physician's Recognition Award" and for credit under the Maryland "Regulations of the Board of Examiners Governing Requirements for Continuing Education for Physicians". Many offerings are also certified for prescribed credit hours by the American Academy of Family Physicians.

A complete listing of courses may be found in the August Continuing Education Supplement of the JAMA, and an updated listing appears monthly in the *Maryland State Medical Journal*.

Please contact the Program of Continuing Education, (301) 528-7346, for further information on these courses or for clarification of any questions you may have concerning education needs. Comments and suggestions for future offerings sponsored by the Program of Continuing Education of the University of Maryland School of Medicine are welcomed.

Looking Ahead: Alumni Reunion June 1, 2, 3, 1977

Wednesday, June 1, 1977
6-11:00 p.m., Cocktail Reception, Davidge Hall

Thursday, June 2, 1977
9:00 a.m., Registration, Davidge Hall
10:00 a.m., Scientific Program, Annual Business Meeting, Davidge Hall
12:30 p.m., Alumni Lunch
7:00 p.m., Reception, Hunt Valley Inn
8:00 p.m., Annual Banquet, Hunt Valley Inn, followed by program and dancing

Friday, June 3, 1977
Commencement

FACULTY NEWS

New Appointments, Promotions, and Resignations

Joseph Aisner, M.D., Assistant Professor—MEDICINE (promotion effective 7/1/76)

Ronald Anthony, Ph.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Richard C. Arbogast, M.D., Assistant Professor—FAMILY MEDICINE (promotion effective 4/1/76)

Antti U. Arstila, M.D., Ph.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Robert J. Ayella, M.D., Professor—RADIOLOGY (promotion effective 7/1/76)

Ruth W. Baldwin, M.D., Clinical Professor—PEDIATRICS (promotion effective 7/1/76)

Joseph W. Burnett, M.D., Professor—MEDICINE (promotion effective 7/1/76)

Joseph W. Byron, Professor—PHARMACOLOGY (promotion effective 7/1/76)

Frank M. Calia, M.D., Professor—MEDICINE (promotion effective 7/1/76)

Gary J. Calton, Ph.D., Associate Professor—MEDICINE (promotion effective 7/1/76)

Richard A. Cash, M.D., Assistant Professor—SOCIAL & PREVENTIVE MEDICINE (promotion effective 3/1/76)

Paul Chang, Assistant Professor—MEDICINE (promotion effective 7/1/76)

Cornelia P. Channing, Ph.D., Professor—PHYSIOLOGY (promotion effective 7/1/76)

Susan M. Cohen, M.D., Assistant Professor—ANESTHESIOLOGY (promotion effective 7/1/76)

Romeo del Rosario, M.D., Assistant Professor—ANESTHESIOLOGY (promotion effective 7/1/76)

John N. Diaconis, M.D., Professor—RADIOLOGY (promotion effective 7/1/76)

Liebe S. Diamond, M.D., Associate Professor—SURGERY (promotion effective 3/1/76)

Michael L. Fisher, M.D., Associate Professor—MEDICINE (promotion effective 7/1/76)

Michael S. Forbes, Ph.D., Assistant Professor—NEUROLOGY (promotion effective 7/1/76)

S. David Gertz, Ph.D, Instructor—NEUROLOGY (promotion effective 7/1/76)

Ghislaine Godenne, M.D., Clinical Associate Professor—PSYCHIATRY (promotion effective 7/1/76)

Sheldon E. Greisman, Professor—PHYSIOLOGY (promotion 7/1/76)

John R. Hankins, M. D., Associate Professor—SURGERY (promotion effective 7/1/76)

Henry T. Harbin, M.D., Assistant Professor—PSYCHIATRY (promotion effective 7/1/76)

Roger C. Harris, M.D., Clinical Assistant Professor—PSYCHIATRY (promotion effective 3/1/76)

Michael G. Hayes, M.D. Assistant Professor—MEDICINE (promotion effective 1/1/76)

Charles E. Hill, M.D., Associate Professor—FAMILY MEDICINE (promotion effective 7/1/76)

William B. Holden, M.D., Clinical Associate Professor—PSYCHIATRY (promotion effective 7/1/76)

John M. Hoopes, Assistant Professor—FAMILY MEDICINE (promotion effective 7/1/76)

Gwynne L. Horwits, M.D., Assistant Professor—ANESTHESIOLOGY (promotion effective 7/1/76)

Shih-Wen Huang, M.D., Associate Professor—PEDIATRICS (promotion effective 7/1/76)

Michael B. Isikoff, M.D., Assistant Professor—RADIOLOGY (promotion effective 7/1/76)

Kook Kim, M.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Brigita Krompholz, M.D., Assistant Professor—SOCIAL & PREVENTIVE MEDICINE (promotion effective 7/1/76)

David A. Kumpe, M.D., reinstated Assistant Professor—RADIOLOGY (effective 4/12/76)

Kauno Laiho, M.D., Ph.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

James J. Lynch, Ph.D. Professor—PSYCHIATRY (promotion effective 7/1/76)

Noel K. Maclaren, M.B.Ch.B., Clinical Associate Professor—PEDIATRICS (promotion effective 7/1/76)

M. Jane Matjasko, M.D., Associate Professor—ANESTHESIOLOGY (promotion effective 7/1/76)

Marguerite T. Moran, M.D., Assistant Professor—MEDICINE (promotion effective 1/1/76)

Thurman N. Mott, Jr., M.D., Associate Professor—PSYCHIATRY (promotion effective 7/1/76)

Elizabeth M. McDowell, Ph.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Deirdre M. McGreehan, M.S.W., Instructor—FAMILY MEDICINE (promotion effective 3/15/76)

Radhamma V. Nair, M.D., Instructor—PEDIATRICS (promotion effective 7/1/76)

Donald M. Pachuta, M.D., Associate Professor—MEDICINE (promotion effective 7/1/76)

S. Michael Plaut, Ph.D., Associate Professor—PSYCHIATRY (promotion effective 7/1/76)

Thongbliew Prempree, M.D., Ph.D., Associate Professor—RADIOLOGY (promotion effective 7/1/76)

J. Eugene Robinson, Ph.D., Professor—RADIOLOGY (promotion effective 7/1/76)

Warren M. Ross, M.D., Assistant Professor—FAMILY MEDICINE (promotion effective 7/1/76)

Edward J. Ruley, M.D., Associate Professor—PEDIATRICS (promotion effective 7/1/76)

Richard M. Sarles, M.D., Associate professor—PEDIATRICS (promotion effective 7/1/76)

Stephen C. Schimpff, M.D., Associate Professor—MEDICINE (promotion effective 7/1/76)

Dennis W. Shermeta, M.D., Associate Professor—SURGERY (promotion effective 7/1/76)

Robert G. Slawson, M.D., Associate Professor—RADIOLOGY (promotion effective 7/1/76)

Merrill J. Snyder, Ph.D., Professor—MEDICINE (promotion effective 7/1/76)

Henry A. Spindler, M.D., Assistant Professor—REHABILITATION MEDICINE (promotion effective 7/1/76)

Judy M. Strum, Ph.D., Associate Professor—ANATOMY (promotion effective 7/1/76)

John C. Sutherland, M.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Granger G. Sutton, Jr., M.D., Associate Professor—NEUROLOGY (promotion effective 7/1/76)

Greta E. Tyson, Ph.D., Associate Professor—PATHOLOGY (promotion effective 7/1/76)

Mariano Veiga, M.D., Clinical Associate Professor—PSYCHIATRY (promotion effective 7/1/76)

W. Douglas Weir, M.D., Associate Professor—PSYCHIATRY (promotion effective 7/1/76); also, Associate Professor—FAMILY MEDICINE (promotion effective 7/1/76)

Peter H. Wiernik, M.D., Professor—MEDICINE (promotion effective 7/1/76)

Rosemarie Wipfelder, M.S., reinstated to Assistant Professor—RADIOLOGY (effective 4/12/76)

Mahmoud F. Abbas, M.D., Clinical Instructor—PSYCHIATRY (appointment effective 7/1/76)

Mohamed S. Al-Ibrahim, Assistant Professor—MEDICINE (appointment effective 1/1/76)

James G. Arnold, Jr., M.D., Professor Emeritus—SURGERY (appointment effective 7/1/76)

Roy A. Axelson, M.D., Assistant Professor—PATHOLOGY (appointment effective 6/1/76)

Alva S. Baker, M.D., Assistant Professor—FAMILY MEDICINE (appointment effective 7/1/76)

James A. Barnhart, Instructor—PHYSICAL THERAPY (appointment effective 2/29/76)

Nasir Bashirelahi, Ph.D., Assistant Professor—SURGERY (appointment effective 3/1/76)

Satish K. Batta, Assistant Professor—PHYSIOLOGY (appointment effective 7/1/76)

Frederick G. Bergmann, M.D., Instructor—SURGERY (appointment effective 7/1/76)

Franklin M. Bialostozky, Instructor—SURGERY (appointment effective 7/1/76)

John F. Brinley, Jr., M.D., Ph.D., Professor—PHYSIOLOGY (appointment effective 6/1/76)

Mireille L. Brown, M.D., Staff Physician—PEDIATRICS (appointment effective 7/6/76)

George H. Brouillet, Jr., M.D., Instructor—SURGERY (appointment effective 7/1/76)

William F. Bruther, M.D., Instructor—OPHTHALMOLOGY (appointment effective 2/1/76)

David Burt, Ph.D., Assistant Professor—PHARMACOLOGY (appointment effective 7/1/76)

Stephen M. Busky, M.D., Instructor—SURGERY (appointment effective 7/1/76)

Dermot P. Byrnes, M.D., Assistant—SURGERY (appointment effective 3/1/76)

Sidney Cohen, M.D., Clinical Assistant Professor—PSYCHIATRY (appointment effective 7/1/76)

Charles H. Dankmeyer, Jr., Instructor—REHABILITATION MEDICINE (appointment effective 9/1/76)

Terry Detrich, M.D., Research Assistant—NEUROLOGY (appointment effective 7/1/76)

Ann Dixon, M.D., Assistant Professor—FORENSIC PATHOLOGY (appointment effective 4/8/76)

Sudhir Dutta, M.B.B.S., Assistant Professor—MEDICINE (appointment effective 7/1/76)

Joel B. Ehrenpreis, B.S., R.T., Assistant—RADIOLOGY (appointment effective 1/5/76)

Amira T. Eldefrawi, Ph.D., Research Associate Professor—PHARMACOLOGY (appointment effective 6/1/76)

Mohyee E. Eldefrawi, Ph.D., Professor—PHARMACOLOGY (appointment effective 6/15/76)

Rupla A. Eshai, M.B.B.S., Clinical Instructor—PEDIATRICS (appointment effective 1/1/76)

Lawrence A. Fleming, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

Richard Foxx, Ph.D., Assistant Professor—PEDIATRICS (appointment effective 11/2/75)

Joshua Frankel, M.D., Clinical Instructor—OPHTHALMOLOGY (appointment effective 4/1/76)

Sandra Goodbody, M.S.W., Instructor—PSYCHIATRY (appointment effective 7/1/76)

David Graham, M.D., Assistant Professor—PEDIATRICS in PSYCHIATRY (appointment effective 9/1/76)

Hormez Guard, M.D., Assistant Professor—FORENSIC PATHOLOGY (appointment effective 4/8/76)

Daniel C. Hardesty, M.D., Instructor—MEDICINE, (appointment effective 7/1/76)

Mary Louise Harty, M.D., Instructor—RADIOLOGY (appointment effective 7/1/76)

Michael C. Hill, M.B.B.Ch., Assistant Professor—RADIOLOGY (appointment effective 7/1/76)

Victor R. Hrehorovich, M.D., Assistant Professor—MEDICINE (appointment effective 7/1/76)

William F. Jessee, M.D., Assistant Dean for Continuing Medical Education and Assistant Professor—SOCIAL AND PREVENTIVE MEDICINE (appointment effective 7/1/76)

Gerald S. Johnston, M.D., Professor—MEDICINE (appointment effective 4/5/76)

Alfred E. Jones, M.D., Associate Professor—MEDICINE (appointment effective 5/1/76)

Radha K. P. Kareti, M.B.B.S., Instructor—ANESTHESIOLOGY (appointment effective 7/1/76)

Said A. Karmi, M.D., Assistant Professor—SURGERY (appointment effective 1/1/76)

Neil M. Keats, M.D., Instructor—SURGERY (appointment effective 7/1/76)

Richard F. Kieffer, Jr., M.D., Associate Professor—SURGERY (appointment effective 5/1/76)

Ill Soo Kim, M.D., Assistant Professor—RADIOLOGY (appointment effective 7/1/76)

Chaparala Kishore, M.B.B.S., Instructor—ANESTHESIOLOGY (appointment effective 7/1/76)

Carol L. Koski, M.D., Assistant Professor—NEUROLOGY (appointment effective 7/1/76)

John Krick, M.S.W., Instructor—FAMILY MEDICINE (appointment effective 6/20/76)

Asta Laamann, M.D., Assistant—SURGERY (appointment effective 3/1/76)

Vinod Lakhanpal, M.B.B.S., Instructor—OPHTHALMOLOGY (appointment effective 7/1/76)

Hubert Leveque, M.D., Instructor—SURGERY (appointment effective 7/1/76)

A. Robert Masten, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

Lawrence Mills, Jr., M.D., Assistant Professor—MEDICINE (appointment effective 7/1/76)

Thomas H. Morgan, M.D., Medical Director of Montebello Center (appointment effective 6/7/76); reinstated as Professor—SURGERY (effective 6/7/76)

Bert Morton, M.D., Assistant Professor—FORENSIC PATHOLOGY (appointment effective 7/1/76)

John H. Mulholland, M.D., Assistant Professor—MEDICINE (appointment effective 7/1/76)

Thomas T. McCloskey, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

Warren D. McNeely, M.D., Clinical Instructor—RADIOLOGY (appointment effective 7/1/76)

Bess J. Naylor, B.S., Instructor—PATHOLOGY (appointment effective 7/1/76)

Joselito C. Ocampo, M.D., Clinical Instructor—PEDIATRICS (appointment effective 7/1/76)

Herbert S. Ormsbee, Ph.D., Assistant Professor—PHYSIOLOGY (appointment effective 7/1/76)

Radhakrishnan Padmanabhan, Ph.D., Assistant Professor—BIOCHEMISTRY (appointment effective 6/1/76)

Padmini Thomas, M.B.B.S., Instructor—ANESTHESIOLOGY (appointment effective 7/1/76)

Shashi K. Pande, M.D., Clinical Associate Professor—PSYCHIATRY (appointment effective 7/1/76)

Frederick N. Pearson, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

Letitia P. Pierce, M.D., Clinical Instructor—PEDIATRICS (appointment effective 7/15/76)

Anthony J. Raneri, M.D., Instructor—SURGERY (appointment effective 7/1/76)

W. Douglas Reed, Ph.D., Assistant Professor—PEDIATRICS (appointment effective 1/1/76)

Walker L. Robinson, M.D., Instructor—SURGERY (appointment effective 7/1/76)

Ann B. Roop, M.S.W., Instructor—PSYCHIATRY (appointment effective 7/1/76)

H. Robert Rubin, M.D., Assistant Professor—FORENSIC PATHOLOGY (appointment effective 4/8/76)

Lyle T. Saylor, MD., Instructor—RADIOLOGY (appointment effective 7/1/76)

Walter C. Schaefer, M.D., Instructor—SURGERY (appointment effective 7/1/76)

Dorothy A. Shannon, Ph.D., Instructor—REHABILITATION MEDICINE (appointment effective 7/1/76)

Charles R. Shear, Ph.D., Associate Professor—ANATOMY (appointment effective 9/1/76)

William I. Smulyan, M.D., Instructor—SURGERY (appointment effective 2/1/76)

John H. Stone, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

C. Frederic Strife, M.D., Assistant Professor—PEDIATRICS (appointment effective 7/1/76)

Bernard Thompson, Ph.D., Clinical Assistant Professor—FORENSIC PATHOLOGY (appointment effective 4/8/76)

James Toop, Ph.D., Instructor—NEUROLOGY (appointment effective 7/1/76)

Dolores C. Walsh, Instructor—PATHOLOGY (appointment effective 1/11/76)

John R. Warfield, M.D., Instructor—RADIOLOGY (appointment effective 7/1/76)

Teena M. Wax, Ph.D., Assistant—PEDIATRICS (appointment effective 4/1/76)

Barry M. Wolk, M.D., Clinical Instructor—OB/GYN (appointment effective 7/1/76)

Celeste L. Woodward, M.D., Instructor—PEDIATRICS (appointment effective 7/1/76)

Lawrence Zerolnick, M.D., Clinical Instructor—PEDIATRICS (appointment effective 7/15/76)

Aye Aye Cho, M.D., Instructor—REHABILITATION MEDICINE (appointment effective 9/1/76)

Carolyn F. Lucas, Instructor—PATHOLOGY (MEDICAL TECHNOLOGY) (appointment effective 7/1/76)

Joan L. Reese, Instructor—PATHOLOGY (MEDICAL TECHNOLOGY) (appointment effective 7/1/76)

Michael A. Berman, M.D., Professor—PEDIATRICS (appointment effective 8/1/76)

Young C. Shin, M.D., Instructor—SURGERY (appointment effective 8/1/76)

Elizabeth B. Harvey, Instructor—NUCLEAR MEDICINE (appointment effective 7/1/76)

Miguel Karacuschansky, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

Donna L. Groul, Research Associate—PHARMACOLOGY (appointment effective 8/9/76)

William E. Randall, M.D., Instructor—MEDICINE (appointment effective 7/1/76)

James A. Barnhart, change in status to full time Instructor—PHYSICAL THERAPY (effective 9/1/76)

Mary L. Oster-Granite, M.D., Assistant Professor—ANATOMY (appointment effective 9/1/76)

James F. Knudsen, Instructor—PHYSICAL THERAPY (appointment effective 9/1/76)

Morton I. Rapoport, M.D., Senior Associate Dean, School of Medicine (appointment effective 7/1/76)

Paul A. Anderson, Instructor—PHYSICAL THERAPY (appointment effective 9/1/76)

Aden Burka, M.D., Instructor—PSYCHIATRY (appointment effective 10/1/76)

Joel W. Renbaum, M.D., Instructor—SURGERY (appointment effective 8/23/76)

James R. Appleton, M.D., Associate—SURGERY (appointment effective 3/1/76)

Nancy Sternberger, M.D., Assistant Professor—ANATOMY (appointment effective 7/1/76)

Jacob K. Delix, M.D., Instructor—PEDIATRICS (appointment effective 8/15/76)

Adbel El-Beshir, M.D., Clinical Instructor—PSYCHIATRY (appointment effective 9/1/76)

John V. Wylie, M.D., Clinical Instructor—PSYCHIATRY (appointment effective 9/1/76)

Joseph L. Young, M.D., Research Associate—NEUROLOGY (appointment effective 9/1/76)

Curtis G. Hayes, M.D., Research Associate—INTERNATIONAL MEDICINE (appointment effective 10/1/76)

ALUMNI NEWS

Randolph Christianson, '74, Milwaukee, Wisconsin, has completed a straight surgical internship at Presbyterian-St. Luke's in Chicago. He is now in the second year of a four-year general surgical residency at St. Joseph's Hospital in Milwaukee.

...

Arthur H. Smith, '63, Augusta, Georgia, has been board-certified in urology and was recently appointed associate professor of urology at the Medical College of Georgia.

...

Jay S. Copeland, '69, Pittsburgh, Pa., has entered into the private practice of urology. He also holds an appointment as clinical instructor in urology at the University of Pittsburgh School of Medicine.

...

Lawrence Mills, '70, Baltimore, has been nemed chief of gastroenterology at Good Samaritan Hospital. Dr. Mills recently completed a two-year fellowship at Case Western Reserve in Cleveland. He is also an assistant professor of medicine at the University of Maryland.

...

Richard J. Kolker, '70, Baltimore, has entered into the private practice of ophthalmology. He was certified by the American Board of Ophthalmology in May of 1976.

...

B. Robert Giangrandi, '63, Ellicott City, Md., was recently elected president of the medical staff at St. Agnes Hospital in Baltimore. He is a diplomate of the American College of Obstetrics and Gynecology and a member of the Maryland Obstetrical and Gynecological Society and has been in private practice since 1968. He completed his residency training in 1968 at St. Agnes Hospital.

...

Eva Dodge, '25, Little Rock, Arkansas, has received the Arkansas Public Health Association's Dr. Tom T. Ross Award, the state's highest award for achievement in the field of public health. Dr. Dodge is currently director of the Arkansas State Health Department's family planning department.

Dr. Dodge was a national pioneer in birth control and child health care. She came to Arkansas in 1945 as associate professor of obstetrics at the University of Arkansas School of Medicine, and retired in 1964 as professor emeritus. She joined the Health Department as a consultant in 1969.

...

Richard C. Reba, '57, Washington D.C., has been appointed professor of radiology and medicine and director of the division of nuclear medicine at the George Washington University Medical Center. He has also been reelected to a four-year term on the board of trustees of the Society of Nuclear Medicine. Dr. Riba has also been appointed to a four-year term on the radiation study section of the National Institutes of Health.

...

Merrill I. Berman, '62, Towson, Maryland, who is Board-certified in general adult psychiatry and child psychiatry, has moved his private practice in child, adolescent, and adult psychiatry, as well as family therapy and biofeedback, to Suite 103, The Ridgely, 205 East Joppa Road, Towson.

...

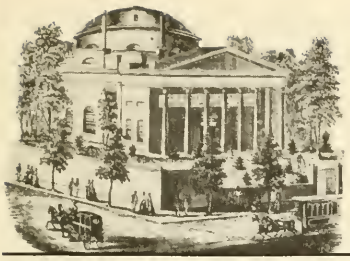
Kenneth Woodrow, '68, Woodside, California, is now engaged in the private practice of psychiatry at 1339 Canado Road, Woodside, California 94062.

...

Stephen K. Padussis, '48, Lutherville, Maryland, was honored with a testimonial dinner and dance on October 8, 1976, for his many years of service to the local community and medical profession. A native of East Baltimore, Dr. Padussis has served on the attending staffs of Church Hospital, Bon Secours, South Baltimore General, and St. Agnes Hospital. At St. Agnes he has chaired numerous committees, served as president of the medical staff, and has been an ex-officio member of the board of trustees. He has been active in many civic and fraternal groups and has been appointed to many state and county agencies. Since 1962 he has served as surgical consultant to the U.S. Social Security Administration's Bureau of Disability.

...

Stephen M. Highstein, '65, recently received his doctorate in physiology from the University of Tokyo Faculty of Medicine. He has been appointed associate professor of neuroscience at the Albert Einstein College of Medicine in New York.



DAVIDGE HALL NOTES

Dedicated to the Restoration and Preservation of the Nation's Oldest Medical School Building

Restoration Underway

On July 1, 1976, the firm of Cochran, Stephenson & Donkervoet began work on the preliminary study of Davidge Hall which will lead to a series of recommendations ultimately resulting in a complete restoration and renovation.

Headed by Mr. W. Boulton Kelly, a team of three architects and numerous consultants identified as professional conservators have been at work for almost 12 weeks. A complete survey of the fabric of the building with additions and alterations is being studied along with the history of the architectural background. Already a number of interesting and hitherto unknown facts have emerged. These will be incorporated in the architect's final report which will appear in *The Bulletin* sometime after January 1, 1977.

The generous support of alumni, friends and foundations has enabled the first phase of this important task to be adequately financed.

Dr. John O. Sharrett resigned as Davidge Hall Restoration Committee Chairman. Dr. Sharrett, who was largely responsible for the organization of the successful start of the restoration of Davidge Hall, resigned his chairmanship on July 1, 1976 but has agreed to maintain his active interest in the project, remaining as a member of the committee. Dr. Sharrett's campaign to raise the necessary funds for the preliminary survey was most successful. He has been succeeded by Dr. John A. Wagner, '38, Professor of Pathology Emeritus.

Davidge Hall Fund (Financial Report)

To date from all sources, a total of $140,000 has been collected. Of this, $41,800 has been obligated for the architectural historical study and recommendations, leaving a balance of $98,200 to be applied toward the ultimate cost of the major task. The committee acknowledges with gratitude grants from the Maryland Historical Trust, the Trustees of the Endowment Fund of the University of Maryland, and the Frank C. Marino Foundation. Additional funds have been received in memory of Dr. Frank H. Figge and Mr. J. Grayson Luttrell.

Major Contributors

The following alumni have made contributions to the Davidge Hall Restoration Fund. It is with profound gratitude that the committee recognizes and thanks these most generous friends of the School of Medicine.

Marvin S. Arons, M.D. '57
Kenneth L. Benfer, M.D. '30
Selig L. Brauer, M.D. '29
Henry T. Brobst, M.D. '43
I. Benedict Bronushas, M.D. '17
Harvey R. Butt, Jr., M.D. '57
Donald D. Cooper, M.D. '38
Harold L. & Miriam A. Daly, M.D. '50
Louis M. Damiano, M.D. '60
Joseph D'Antonio, M.D. '46
Andrew J. Devlin, M.D. '52
Patricia Dodd, M.D. '44
Guy K. Driggs, M.D. '46
Victor Drucker, M.D. '33
William J. R. Dunseath, M.D. '59
Sylvan Frieman, M.D. '53
Walter D. Gable, M.D. '54
Paul H. Gislason, M.D. '52
Wilson A. Heefner, M.D. '60
Charles A. Hefner, M.D. '46
Albert H. Jackvony, M.D. '20
Arthur F. Jones, Jr., M.D. '59
D. Frank Kaltreider, M.D. '37
August D. King, Jr., M.D. '59
John C. Krantz, Jr., Ph.D. '99
H. Pearce MacCubbin, M.D. '40
Herbert M. Marton, M.D. '56
George L. Morningstar, M.D. '55
Dept. of Ophthalmology—R. Richards, M.D.
Conrad L. Richter, M.D. '40
Oliver Ralph Roth, M.D. '50
Wallace H. Sadowsky, M.D. '42
Benjamin M. Stein, M.D. '35
John R. Stram, M.D. '60
Robert A. Stram, M.D. '66
D.S. Rasmussen Taxdal, M.D. '52
A. Frank Thompson, Jr., M.D. '40
Raymond K. Thompson, M.D. '41

Millard T. Traband, Jr., M.D. '44
Max Trubek, M.D. '26
Isadore Tuerk, M.D. '34
Robert C. Waltz, M.D. '47
Bryan P. Warren, M.D. '24
Frank O. Warren, Jr., M.D. '43
Celeste L. Woodward, M.D. '38
Theodore E. Woodward, M.D. '38
George H. Yeager, M.D. '29
James B. Zimmerman, M.D. '58

Each member has been entered on the rolls of the Davidge Charter and has received an appropriate individualized plaque recognizing their contribution.

Committee Launches Restoration Fund Drive

Colored reproductions of Davidge Hall and of the old University Hospitals are available on subscription.

Several years ago, artists Paul Vicino and Larry Wheeler were commissioned to paint Davidge Hall as it currently exists and their interpretation of the old hospitals which contributed to the eminence of the School of Medicine. The originals of these hang in the foyer of the University of Maryland Hospital.

Recently the Davidge Hall Committee arranged for a limited edition of signed lithograph reproductions of these four paintings available on subscription for $150. The proceeds, after expenses, are to be applied to the Davidge Hall Fund. Elsewhere in this edition, these paintings are reproduced and are accompanied by an appropriate order blank. The edition is limited to 2,000 signed copies.

Pewter Plates Yet Available

Of the original edition of pewter plates issued in support of the Davidge Hall Restoration, approximately 90 remain to be distributed. These are available for subscription for $100. Please use the subscription coupon printed elsewhere in this issue.

Program of Combined Activities for the Bicentennial Celebration

December 6, 7, 8 and 9, 1976

Bicentennial Celebration

Davidge Hall, Monday, December 6, 1:00 pm

Invocation: Rabbi Robert Saks

The National Anthem: *The Star-Spangled Banner,* sung by the Combined University Choral Groups, Professor Fague K. Springman, Conductor

Greetings

B. Herbert Brown, Chairman, Board of Regents; Wilson H. Elkins, President, University of Maryland; Albin O. Kuhn, Chancellor, University of Maryland at Baltimore; John M. Dennis, Vice Chancellor for Health Affairs and Dean, University of Maryland School of Medicine.

Musical Selection: *Battle Hymn of the Republic,* Arr. Waring.

Dedication of Davidge Hall

Address: The Twentieth Maurice C. Pincoffs Lecture, The Honorable Rogers C.B. Morton

Conferring of Honorary Degree by Dr. Wilson H. Elkins

Benediction: Chaplain Carl H. Greenawald

Break for Refreshments

Historical Vignettes

Hon. Louis L. Goldstein, Comptroller, State of Maryland—"Maryland: America in Miniature"

Walter Lord, Distinguished Author of The Dawn's Early Light and A Night to Remember—"How Lack of Medical Knowledge Once Saved Baltimore"

Thomas B. Turner, M.D., Graduate 1925; Hon. Sc. D. 1966; Alumni Award 1968; and Dean Emeritus of the Medical Faculty of the Johns Hopkins University—"Reflections on Medical Education"

Reception and Dinner

Maryland Club, Charles and Eager Streets

Monday Evening, December 6, 6:15 pm

Reception and Dinner by Invitation and Subscription

Evening Musicale

Davidge Hall

Monday Evening, December 6, 8:15 pm

Glee Club, University of Maryland

Professor Fague K. Springman, Conductor

• • •

Combined Meeting of University of Maryland Hospital Surgical and Medical Associations and the Bradley Pediatric Society in conjunction with Alumni Association by former staff members and alumni of the University of Maryland School of Medicine and Hospital

Program in Internal Medicine

Davidge Hall

Tuesday, December 7, 9:00 am

N. David Charkes, M.D.
"The Impact of Radioisotope Bone Scans on Medical Practice"

Mario R. Garcia-Palmieri, M.D.
"The Spectrum of Cardiac Disorders in Puerto Rico"

Norton Spritz, M.D.
"Mechanisms in the Development of the Complications of Diabetes Mellitus"

David A. Levy, M.D.
"A Decade with IgE"

Break for Refreshments

Arthur H. Schmale, Jr., M.D.
"Psychic Controls of Somatic Functioning"

Kenneth Zierler, M.D.
"Function of Cell Membranes in Health and Disease"

Richard P. Wenzel, M.D.
"Hospital Acquired Infections"

Leonard J. Morse, M.D.
"Epidemiologic Practice Outside of the Ivory Tower"

Bradley Pediatric Society

Chemical Hall—Davidge Hall Building

Tuesday, December 7, 1976, 9:00 am

Edward J. Ruley, M.D., Moderator

Greetings
Marvin Cornblath, M.D.

Maria Gumbinas, M.D.
"Migraine Headaches in Children"

Fred J. Heldrich, M.D.
"Urinary Track Infections in Children"

Michael A. Berman, M.D.
"Recent Advances in Pediatric Cardiology"

Break for Refreshments

Marianne Felice, M.D.
"Adolescent Sexuality"

Ronald L. Gutberlet, M.D.
"Treatment of Respiratory Distress Syndrome: Current Concepts"

Arnold Brenner, M.D.
"Unorthodox Treatment of Hyperkinesis: Feingold Diet and Megavitamins"

Luncheon

Surgical Society Scientific Program

Room 256, Howard Hall

Tuesday, December 7, 9:00 am

William S. Kiser, M.D.
"The Industrialization of American Medicine: For Better or Worse?"

John F. Mullan, M.D.
"Selection of Surgical Residents" and "Current Modes of Therapy for Cerebrovascular Disease"

John Earle Bordley, M.D.
"Thoughts on the Future of Otolaryngology"

Biennial Business Meeting

Hermes C. Grillo, M.D.
"Problems in Repair of the Windpipe"

Wayne O. Southwick, M.D.
"Cervical Spine Injuries—Treatment Rational"

Robert M. Zollinger, M.D.
"Islet Cell Tumors and the Gastrointestinal Tract"

Clinical and Surgical Rounds

Wednesday, December 8

Surgical specialties will sponsor individual clinical and surgical rounds. Programs are available from Dr. Joseph S. McLaughlin's office, 301-528-5842.

Orthopedic Day

Hilton Hotel

Reisterstown Road at the Beltway

Thursday, December 9, 8:30 am—4:30 pm

Charles C. Edwards, M.D., Moderator

Faculty to include Dr. Wayne O. Southwick and Dr. Gerhard Schmeisser

Medical Alumni Association

During the Bicentennial proceedings, the Alumni Office (2nd floor, Davidge Hall) will be open and pleased to receive visitors.

Please stop by, have a cup of coffee or soft drink, and chat with members of your Board of Directors and see the progress that is being made toward restoring Davidge Hall.

ALUMNI NEWS REPORT

TO THE BULLETIN:

I would like to report the following: _____

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SUGGESTIONS FOR ITEMS

American Board Certification

Change of Office or Address

Residency Appointment

Research Completed

News of Another Alumnus

Academic Appointment

Interesting Historic Photographs and Artifacts

Scientific Articles

Name _____

Address _____

_____

Class _____

Send To: George H. Yeager, M.D.
Editor, Alumni Bulletin
University of Maryland
School of Medicine
Room 107 Gray Laboratory
Baltimore, Maryland 21201

HISTORICAL PRINTS AVAILABLE

Several years ago two artists were commissioned to paint Davidge Hall and the three "old' hospitals: Baltimore Infirmary, 1823, and the University Hospital of 1870 and 1890.

High quality, signed and numbered reproductions of these original Historical Prints in a limited edition are now available. Arrangements have been made to mail one set of each of the four prints, accompanied by an insert describing the structures and artists, to those contributing $150.00 to the Davidge Hall Restoration Fund.

As the edition is limited, your early response is strongly advised.

John A. Wagner, M.D.
Chairman
Davidge Hall Restoration Committee

(Note: individual prints are not available—prints can be sold in sets of four only.)

Davidge Hall Restoration Fund
Medical Alumni Association
522 W. Lombard Street
Baltimore, Maryland 21201

Order Form

Enclosed is my contribution to the Davidge Hall Restoration Fund for $_____. In consideration of my contribution, please mail me *one* set of the Historical Prints for *each* $150.00 contributed.

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Street _____

City _____ State _____ Zip _____

Please make checks payable to: Davidge Hall Restoration Fund

(Note: this is a tax deductible item.)

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Part-time position available for General Practice or Family Practice physician. Twelve man multi-specialty group practice located in Eastern Baltimore County. Afternoon, evening and Saturday morning hours available. Need coverage 18 hrs./week minimum. Send curriculum vitae to: P. Piasecki, 1107 North Point Blvd., Suite 203, Baltimore, Md. 21224.

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In Memoriam

Margaret B. Ballard, M.D. 1900-1976

Margaret Byrnside Ballard, M.D., Class of 1926, erstwhile professor in the School of Medicine and since her retirement in 1965 a resident of Union, West Virginia, died on September 29, 1976.

A native of Greenville, West Virginia, Maggie, as she was affectionately called, completed her premedical training at the University of West Virginia. Following her graduation from the School of Medicine, she entered the practice of Obstetrics and Gynecology, serving continuously on the staffs of many clinics and hospitals including the Hospital of the University of Maryland. She also enjoyed an active and rewarding private practice.

This diminutive, energetic, friendly and compassionate person made two great contributions, first to medicine and then to her Alma Mater.

During the years when the words "family planning" or "contraception" were not spoken in public, Dr. Ballard was foremost among the few who organized, and openly advocated, family planning as a facet of the speciality of gynecology. Professionally she became eminently qualified and her opinions and advice were widely sought.

In 1956, she completed a monumental work, "A University is Born," concerning sequential development of the University of Maryland and, particularly, of the School of Medicine, organized in 1807, and parent school of the University.

Following her retirement, she returned to the green hills and valleys of her homeland to devote the remaining active years of her life to studies and publications relating to the history of West Virginia. On several occasions, she was honored officially through membership on historical commissions appointed by the Governor of the State.

An eminent person, a loyal alumna, a fine, friendly and ethical person, her contribution to her Alma Mater and to the welfare of her nation will indeed endure.

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